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104TH CONGRESS
2D SESSION

H. R. 3070

To improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, and to simplify the administration of health insurance.

IN THE HOUSE OF REPRESENTATIVES

MARCH 12, 1996

Mr. BILIRAKIS (for himself and Mr. BLILEY) introduced the following bill; which was referred to the Committee on Commerce, and Committees on Ways and Means, the Judiciary, and Economic and Educational Opportunities, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, and to simplify the administration of health insurance.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Coverage Availability and Affordability Act of 1996''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—IMPROVED AVAILABILITY AND PORTABILITY OF HEALTH INSURANCE COVERAGE

Subtitle A—Coverage Under Group Health Plans

SEC. 101. PORTABILITY OF COVERAGE FOR PREVIOUSLY COVERED INDIVIDUALS.

(a) CREDITING PERIODS OF PREVIOUS COVERAGE TOWARD PREEXISTING CONDITION RESTRICTIONS.—Subject to the succeeding provisions of this section, a group health plan, and an insurer or health maintenance organization offering health insurance coverage in connection with a group health plan, shall provide that any preexisting condition limitation period (as defined in subsection (b)(2)) is reduced by the length of the aggregate period of qualified prior coverage (if any, as defined in subsection (b)(3)) applicable to the participant or beneficiary as of the date of commencement of coverage under the plan.

(b) DEFINITIONS AND OTHER PROVISIONS RELATING TO PREEXISTING CONDITIONS.—

(1) PREEXISTING CONDITION.—

(A) IN GENERAL.—For purposes of this subtitle, subject to subparagraph (B), the term ''preexisting condition'' means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the day before—

(i) the effective date of the coverage of such participant or beneficiary, or

(ii) the earliest date upon which such coverage could have been effective if there were no waiting period applicable,

whichever is earlier.

(B) EXTENSION OF PERIOD IN THE CASE OF LATE ENROLLMENT.—In the case of a participant or beneficiary whose initial coverage commences after the date the participant or beneficiary first becomes eligible for coverage under the group health plan, the reference in subparagraph (A) to ''6-month period'' is deemed a reference to ''12-month period''.

(2) PREEXISTING CONDITION LIMITATION PERIOD.—For purposes of this subtitle, the term ''preexisting condition limitation period'' means, with respect to coverage of an individual under a group health plan or under health insurance coverage, the period during which benefits with respect to treatment of a condition of such individual are not provided based on the fact that the condition is a preexisting condition.

(3) AGGREGATE PERIOD OF QUALIFIED PRIOR COVERAGE.—

(A) IN GENERAL.—For purposes of this section, the term ''aggregate period of qualified prior coverage'' means, with respect to commencement of coverage of an individual under a group health plan or health insurance coverage offered in connection with a group health plan, the aggregate of the qualified coverage periods (as defined in subparagraph (B)) of such individual occurring before the date of such commencement. Such period shall be treated as zero if there is more than a 60-day break in coverage under a group health plan (or health insurance coverage offered in connection with such a plan) between the date the most recent

qualified coverage period ends and the date of such commencement.

(B) QUALIFIED COVERAGE PERIOD.—

(i) IN GENERAL.—For purposes of this paragraph, subject to subsection (c), the term ''qualified coverage period'' means, with respect to an individual, any period of coverage of the individual under a group health plan, health insurance coverage, or under title XIX of the Social Security Act.

(ii) DISREGARDING PERIODS BEFORE BREAKS IN COVERAGE.—Such term does not include any period occurring before any 60-day break in coverage described in subparagraph (A).

(C) WAITING PERIOD NOT TREATED AS A BREAK IN COVERAGE.—For purposes of subparagraphs (A) and (B), any period that is in a waiting period for any coverage under a group health plan (or for health insurance coverage offered in connection with a group health plan) shall not be considered to be a break in coverage described in subparagraph (B)(ii).

(D) ESTABLISHMENT OF PERIOD.—A qualified coverage period with respect to an individual shall be established through presentation of certifications described in subsection (c) or in such other manner as may be specified in regulations to carry out this section.

(c) CERTIFICATIONS OF COVERAGE; CONFORMING COVERAGE.—

(1) IN GENERAL.—The plan administrator of a group health plan, or the insurer or HMO offering health insurance coverage in connection with a group health plan, shall, on request made on behalf of an individual covered (or previously covered within the previous 18 months) under the plan or coverage, provide for a certification of the period of coverage of the individual under such plan or coverage and of the waiting period (if any) imposed with respect to the individual for any coverage under the plan.

(2) STANDARD METHOD.—Subject to paragraph (3), a group health plan, or insurer or HMO offering health insurance coverage in connection with a group health plan, shall determine qualified coverage periods under subsection (b)(3)(B) by including all periods described in such subsection, without regard to the specific benefits offered during such a period.

(3) ALTERNATIVE METHOD.—Such a plan, insurer, or HMO may elect to make such determination on a benefit-specific basis for all participants and beneficiaries and not to include as a qualified coverage period with respect to a specific benefit coverage during a previous period unless such previous coverage for that benefit was included at the end of the most recent period of coverage. In the case of such an election—

(A) the plan, insurer, or HMO shall prominently state in any disclosure statements concerning the plan or coverage and to each enrollee at the time of enrollment under the plan (or at the time the health insurance coverage is offered for sale in the group health market) that the plan or coverage has made such election and shall include a description of the effect of this election; and

(B) upon the request of the plan, insurer, or HMO, the entity providing a certification under paragraph (1)—

(i) shall promptly disclose to the requesting plan, insurer, or HMO the plan statement (insofar as it relates to health benefits under the plan) or other detailed

benefit information on the benefits available under the previous plan or coverage, and

(ii) may charge for the reasonable cost of providing such information.

SEC. 102. LIMITATION ON PREEXISTING CONDITION EXCLUSIONS; NO APPLICATION TO CERTAIN NEWBORNS, ADOPTED CHILDREN, AND PREGNANCY.

(a) LIMITATION OF PERIOD.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, a group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, shall provide that any preexisting condition limitation period (as defined in section 101(b)(2)) does not exceed 12 months, counting from the effective date of coverage.

(2) EXTENSION OF PERIOD IN THE CASE OF LATE ENROLLMENT.—In the case of a participant or beneficiary whose initial coverage commences after the date the participant or beneficiary first becomes eligible for coverage under the group health plan, the reference in paragraph (1) to ''12 months'' is deemed a reference to ''18 months''.

(b) EXCLUSION NOT APPLICABLE TO CERTAIN NEWBORNS AND CERTAIN ADOPTIONS.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, may not provide any limitation on benefits based on the existence of a preexisting condition in the case of—

(A) an individual who within the 30-day period beginning with the date of birth, or

(B) an adopted child or a child placed for adoption beginning at the time of adoption or placement if the individual, within the 30-day period beginning on the date of adoption or placement,

becomes covered under a group health plan or otherwise becomes covered under health insurance coverage (or covered for medical assistance under title XIX of the Social Security Act).

(2) LOSS IF BREAK IN COVERAGE.—Paragraph (1) shall no longer apply to an individual if the individual does not have any coverage under a group health plan, health insurance coverage, or under title XIX of the Social Security Act for a continuous period of 60 days, not counting in such period any

days that are in a waiting period for any coverage under a group health plan.

(3) PLACED FOR ADOPTION DEFINED.—In this subsection and section 103(d), the term ''placement'', or being ''placed'', for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

(c) EXCLUSION NOT APPLICABLE TO PREGNANCY.—For purposes of this section, pregnancy shall not be treated as a preexisting condition.

(d) ELIGIBILITY PERIOD IMPOSED BY HEALTH MAINTENANCE ORGANIZATIONS AS ALTERNATIVE TO PREEXISTING CONDITION LIMITATION.—A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not use the preexisting condition limitations allowed under this section and section 101 with respect to any particular coverage option may impose an eligibility period for such coverage option, but only if such period does not exceed—

(1) 90 days, in the case of a participant or beneficiary whose initial coverage commences at the time such participant or beneficiary first becomes eligible for coverage under the plan, or

(2) 180 days, in the case of a participant or beneficiary whose initial coverage commences after the date on which such participant or beneficiary first becomes eligible for coverage.

For purposes of this subsection, the term ''eligibility period'' means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. Any such eligibility period shall be treated for purposes of this subtitle as a waiting period under the plan and shall run concurrently with any other applicable waiting period under the plan.

SEC. 103. PROHIBITING EXCLUSIONS BASED ON HEALTH STATUS AND PROVIDING FOR ENROLLMENT PERIODS.

(a) PROHIBITION OF EXCLUSION OF PARTICIPANTS OR BENEFICIARIES BASED ON HEALTH STATUS.—

(1) IN GENERAL.—A group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, may not exclude an employee or his or her beneficiary from

being (or continuing to be) a participant or beneficiary under the terms of such plan or coverage based on health status (as defined in section 191(c)(6)).

(2) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the establishment of preexisting condition limitations and restrictions to the extent consistent with the provisions of this subtitle.

(b) ENROLLMENT OF ELIGIBLE INDIVIDUALS WHO LOSE OTHER COVERAGE.—A group health plan shall permit an uncovered employee who is otherwise eligible for coverage under the terms of the plan (or an uncovered dependent, as defined under the terms of the plan, of such an employee, if family coverage is available) to enroll for coverage under the plan under at least one benefit option if each of the following conditions is met:

(1) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or individual.

(2) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment.

(3) The employee or dependent lost coverage under a group health plan or health insurance coverage (as a result of loss of eligibility for the coverage, termination of employment, or reduction in the number of hours of employment).

(4) The employee requests such enrollment within 30 days after the date of termination of such coverage.

(c) DEPENDENT BENEFICIARIES.—

(1) IN GENERAL.—If a group health plan makes family coverage available, the plan may not require, as a condition of coverage of an individual as a dependent (as defined under the terms of the plan) of a participant in the plan, a waiting period applicable to the coverage of a dependent who—

(A) is a newborn,

(B) is an adopted child or child placed for adoption (within the meaning of section 102(b)(3)), at the time of adoption or placement, or

(C) is a spouse, at the time of marriage,

if the participant has met any waiting period applicable to that participant.

(2) TIMELY ENROLLMENT.—

(A) IN GENERAL.—Enrollment of a participant's beneficiary described in paragraph (1) shall be considered to be timely if a request for enrollment is made within 30 days of the date family coverage is first made available or, in the case described in—

(i) paragraph (1)(A), within 30 days of the date of the birth,

(ii) paragraph (1)(B), within 30 days of the date of the adoption or placement for adoption, or

(iii) paragraph (1)(C), within 30 days of the date of the marriage with such a beneficiary who is the spouse of the participant,

if family coverage is available as of such date.

(B) COVERAGE.—If available coverage includes family coverage and enrollment is made under such coverage on a timely basis under subparagraph (A), the coverage shall become effective not later than the first day of the first month beginning 15 days after the date the completed request for enrollment is received.

SEC. 104. ENFORCEMENT.

(a) ENFORCEMENT THROUGH COBRA PROVISIONS IN INTERNAL REVENUE CODE.—

(1) APPLICATION OF COBRA SANCTIONS.—Subsection (a) of section 4980B of the Internal Revenue Code of 1986 is amended by striking ''the requirements of'' and all that follows and inserting ''the requirements of—

''(1) subsection (f) with respect to any qualified beneficiary, or

''(2) subject to subsection (h)—

''(A) section 101 or 102 of the Health Coverage Availability and Affordability Act of 1996 with respect to any individual covered under the group health plan, or

''(B) section 103 of such Act with respect to any individual.''.

(2) NOTICE REQUIREMENT.—Section 4980B(f)(6)(A) of such Code is amended by inserting before the period the following: ''and subtitle A of title I of the Health Coverage Availability and Affordability Act of 1996''.

(3) SPECIAL RULES.—Section 4980B of such Code is amended by adding at the end the following:

''(h) SPECIAL RULES.—For purposes of applying this section in the case of requirements described in subsection

(a)(2) relating to section 101, section 102, or section 103 of the Health Coverage Availability and Affordability Act of 1996—

''(1) DEFERRAL TO STATE REGULATION.—No tax shall be imposed by this section on any failure to meet the requirements of such section by any entity which offers health insurance coverage and which is an insurer or health maintenance organization (as defined in section 191(c) of the Health Coverage Availability and Affordability Act of 1996) regulated by a State if the Secretary of Health and Human Services has made the determination described in section 104(c)(2) of such Act with respect to such State, section, and entity.

''(2) LIMITATION FOR INSURED PLANS.—In the case of a group health plan of a small employer (as defined in section 191 of the Health Coverage Availability and Affordability Act of 1996) that provides health care benefits solely through a contract with an insurer or health maintenance organization (as defined in such section), no tax shall be imposed by this section upon the employer on a failure to meet such requirements if the failure is solely because of the product offered by the insurer or organization under such contract.

''(3) LIMITATION ON IMPOSITION OF TAX.—In no case shall a tax be imposed by this section for a failure to meet such a requirement if a sanction has been imposed—

''(A) by the Secretary of Labor under part 5 of subtitle A of title I of the Employee Retirement Income Security Act of 1974 with respect to such failure, or

''(B) by the Secretary of Health and Human Services under section 109 of the Health Coverage Availability and Affordability Act of 1996 with respect to such failure.''.

(b) ENFORCEMENT THROUGH ERISA SANCTIONS FOR CERTAIN GROUP HEALTH PLANS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, sections 101 through 103 of this subtitle shall be deemed to be provisions of title I of the Employee Retirement Income Security Act of 1974 for purposes of applying such title.

(2) FEDERAL ENFORCEMENT ONLY IF NO ENFORCEMENT THROUGH STATE.—The Secretary of Labor shall enforce each section referred to in paragraph (1) with respect to any entity which is an insurer or health maintenance organization regulated

by a State only if the Secretary of Labor determines that—

(A) such State has not provided for enforcement of State laws which govern the same matters as are governed by such section and which require compliance by such entity with at least the same requirements as those provided under such section, and

(B) such entity has failed to comply with such requirements of such section as are applicable to such entity.

(3) LIMITATIONS ON LIABILITY.—

(A) NO APPLICATION WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No liability shall be imposed under this subsection on the basis of any failure during any period for which it is established to the satisfaction of the Secretary of Labor that none of the persons against whom the liability would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(B) NO APPLICATION WHERE FAILURE CORRECTED WITHIN 30 DAYS.—No liability shall be imposed under this subsection on the

basis of any failure if such failure was due to reasonable cause and not to willful neglect, and such failure is corrected during the 30-day period beginning on the first day any of the persons against whom the liability would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(4) AVOIDING DUPLICATION OF CERTAIN PENALTIES.—In no case shall a civil money penalty be imposed under the authority provided under paragraph (1) for a violation of this subtitle for which an excise tax has been imposed under section 4980B of the Internal Revenue Code of 1986 or a civil money penalty imposed under subsection (c).

(c) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

(1) IMPOSITION.—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, any group health plan, insurer, or organization that fails to meet a requirement of this subtitle is subject to a civil money penalty under this section.

(B) LIABILITY FOR PENALTY.—Rules similar to the rules described in section 4980B(e) of the Internal Revenue Code of 1986 for liability

for a tax imposed under section 4980B(a) of such Code shall apply to liability for a penalty imposed under subparagraph (A).

(C) AMOUNT OF PENALTY.—

(i) IN GENERAL.—The maximum amount of penalty imposed under this paragraph is $100 for each day for each individual with respect to which such a failure occurs.

(ii) CONSIDERATIONS IN IMPOSITION.—In determining the amount of any penalty to be assessed under this paragraph, the Secretary of Health and Human Services shall take into account the previous record of compliance of the person being assessed with the applicable requirements of this subtitle, the gravity of the violation, and the overall limitations for unintentional failures provided under section 4980B(c)(4) of the Internal Revenue Code of 1986.

(iii) LIMITATIONS.—

(I) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILI-

GENCE.—No civil money penalty shall be imposed under this paragraph on any failure during any period for which it is established to the satisfaction of the Secretary that none of the persons against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(II) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No civil money penalty shall be imposed under this paragraph on any failure if such failure was due to reasonable cause and not to willful neglect, and such failure is corrected during the 30-day period beginning on the first day any of the persons against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(D) ADMINISTRATIVE REVIEW.—

(i) OPPORTUNITY FOR HEARING.—The person assessed shall be afforded an

opportunity for hearing by the Secretary upon request made within 30 days after the date of the issuance of a notice of assessment. In such hearing the decision shall be made on the record pursuant to section 554 of title 5, United States Code. If no hearing is requested, the assessment shall constitute a final and unappealable order.

(ii) HEARING PROCEDURE.—If a hearing is requested, the initial agency decision shall be made by an administrative law judge, and such decision shall become the final order unless the Secretary modifies or vacates the decision. Notice of intent to modify or vacate the decision of the administrative law judge shall be issued to the parties within 30 days after the date of the decision of the judge. A final order which takes effect under this paragraph shall be subject to review only as provided under subparagraph (D).

(E) JUDICIAL REVIEW.—

(i) FILING OF ACTION FOR REVIEW.—Any person against whom an order impos-

ing a civil money penalty has been entered after an agency hearing under this paragraph may obtain review by the United States district court for any district in which such person is located or the United States District Court for the District of Columbia by filing a notice of appeal in such court within 30 days from the date of such order, and simultaneously sending a copy of such notice be registered mail to the Secretary.

(ii) CERTIFICATION OF ADMINISTRATIVE RECORD.—The Secretary shall promptly certify and file in such court the record upon which the penalty was imposed.

(iii) STANDARD FOR REVIEW.—The findings of the Secretary shall be set aside only if found to be unsupported by substantial evidence as provided by section 706(2)(E) of title 5, United States Code.

(iv) APPEAL.—Any final decision, order, or judgment of such district court concerning such review shall be subject to

appeal as provided in chapter 83 of title 28 of such Code.

(F) FAILURE TO PAY ASSESSMENT; MAINTENANCE OF ACTION.—

(i) FAILURE TO PAY ASSESSMENT.—If any person fails to pay an assessment after it has become a final and unappealable order, or after the court has entered final judgment in favor of the Secretary, the Secretary shall refer the matter to the Attorney General who shall recover the amount assessed by action in the appropriate United States district court.

(ii) NONREVIEWABILITY.—In such action the validity and appropriateness of the final order imposing the penalty shall not be subject to review.

(G) PAYMENT OF PENALTIES.—Except as otherwise provided, penalties collected under this paragraph shall be paid to the Secretary (or other officer) imposing the penalty and shall be available without appropriation and until expended for the purpose of enforcing the provisions with respect to which the penalty was imposed.

(2) FEDERAL ENFORCEMENT ONLY IF NO ENFORCEMENT THROUGH STATE.—Paragraph (1) shall not apply to enforcement of the requirements of section 101, 102, or 103 with respect to any entity which offers health insurance coverage and which is an insurer or HMO regulated by a State if the Secretary of Health and Human Services has determined that—

(A) such State has not provided for enforcement of State laws which govern the same matters as are governed by such section and which require compliance by such entity with at least the same requirements as those provided under such section, and

(B) such entity has failed to comply with such requirements of such section as are applicable to such entity.

(3) NONDUPLICATION OF SANCTIONS.—In no case shall a civil money penalty be imposed under this subsection for a violation of this subtitle for which an excise tax has been imposed under section 4980B of the Internal Revenue Code of 1986 or for which a civil money penalty has been imposed under the authority provided under subsection (b).

(d) COORDINATION IN ADMINISTRATION.—The Secretaries of the Treasury, Labor, and Health and Human Services shall issue regulations that are nonduplicative to carry out this subtitle. Such regulations shall be issued in a manner that assures coordination and nonduplication in their activities under this subtitle.

Subtitle B—Certain Requirements for Insurers and HMOs in the Group and Individual Markets

PART 1—AVAILABILITY OF GROUP HEALTH INSURANCE COVERAGE

SEC. 131. GUARANTEED AVAILABILITY OF GENERAL COVERAGE IN THE SMALL GROUP MARKET.

(a) ISSUANCE OF COVERAGE.—

(1) IN GENERAL.—Subject to the succeeding subsections of this section, each insurer or HMO that offers health insurance coverage in the small group market in a State—

(A) must accept every small employer in the State that applies for such coverage; and

(B) must accept for enrollment under such coverage every eligible individual (as defined in paragraph (2)) who applies for enrollment during the initial period in which the individual first becomes eligible for coverage under the

group health plan and may not place any restriction which is inconsistent with section 103(a) on an individual being a participant or beneficiary so long as such individual is an eligible individual.

(2) ELIGIBLE INDIVIDUAL DEFINED.—In this section, the term ''eligible individual'' means, with respect to an insurer or HMO that offers health insurance coverage to any small employer in the small group market, such an individual in relation to the employer as shall be determined—

(A) in accordance with the terms of such plan,

(B) as provided by the insurer or HMO under rules of the insurer or HMO which are uniformly applicable, and

(C) in accordance with all applicable State laws governing such insurer or HMO.

(b) SPECIAL RULES FOR NETWORK PLANS AND HMOS.—

(1) IN GENERAL.—In the case of an insurer that offers health insurance coverage in the small group market through a network plan and in the case of an HMO that offers health insurance cov-

erage in connection with such a plan, the insurer or HMO may—

(A) limit the employers that may apply for such coverage to those with eligible individuals whose place of employment or residence is in the service area for such plan or HMO;

(B) limit the individuals who may be enrolled under such coverage to those whose place of residence or employment is within the service area for such plan or HMO; and

(C) within the service area of such plan or HMO, deny such coverage to such employers if the insurer or HMO demonstrates that—

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this paragraph uniformly to all employers without regard to the claims experience of those employers and their employees (and their beneficiaries) or the health status of such employees and beneficiaries.

(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An insurer or HMO, upon denying health insurance coverage in any service area in accordance with paragraph (1)(C), may not offer coverage in the small group market within such service area for a period of 180 days after such coverage is denied.

(c) SPECIAL RULE FOR FINANCIAL CAPACITY LIMITS.—

(1) IN GENERAL.—An insurer or HMO may deny health insurance coverage in the small group market if the insurer or HMO demonstrates to the applicable State authority that—

(A) it does not have the financial reserves necessary to underwrite additional coverage, and

(B) it is applying this paragraph uniformly to all employers without regard to the claims experience or duration of coverage of those employers and their employees (and their beneficiaries) or the health status of such employees and beneficiaries.

(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An insurer or HMO upon denying health insurance coverage in connection with group

health plans in any service area in accordance with paragraph (1) may not offer coverage in connection with group health plans in the small group market within such service area for a period of 180 days after such coverage is denied.

(d) EXCEPTION TO REQUIREMENT FOR ISSUANCE OF COVERAGE BY REASON OF FAILURE BY PLAN TO MEET CERTAIN MINIMUM PARTICIPATION OR CONTRIBUTION RULES.—

(1) IN GENERAL.—Subsection (a) shall not apply in the case of any group health plan with respect to which—

(A) participation rules of an insurer or HMO which are described in paragraph (2) are not met, or

(B) contribution rules of an insurer or HMO which are described in paragraph (3) are not met.

(2) PARTICIPATION RULES.—For purposes of paragraph (1)(A), participation rules (if any) of an insurer or HMO shall be treated as met with respect to a group health plan only if such rules are uniformly applicable and in accordance with applicable State law and the number or percentage of eligible individuals who, under the plan, are participants or

beneficiaries equals or exceeds a level which is determined in accordance with such rules.

(3) CONTRIBUTION RULES.—For purposes of paragraph (1)(B), contribution rules (if any) of an insurer or HMO shall be treated as met with respect to a group health plan only if such rules are in accordance with applicable State law.

SEC. 132. GUARANTEED RENEWABILITY OF GROUP COVERAGE.

(a) IN GENERAL.—Except as provided in this section, if an insurer or health maintenance organization offers health insurance coverage in the small or large group market, the insurer or organization must renew or continue in force such coverage at the option of the employer.

(b) GENERAL EXCEPTIONS.—An insurer or organization may nonrenew or discontinue health insurance coverage offered an employer based only on one or more of the following:

(1) NONPAYMENT OF PREMIUMS.—The employer has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the insurer or organization has not received timely premium payments.

(2) FRAUD.—The employer has performed an act or practice that constitutes fraud or made an in-

tentional misrepresentation of material fact under the terms of the coverage.

(3) VIOLATION WITH PARTICIPATION OR CONTRIBUTION RULES.—The group purchaser has failed to comply with a material plan provision relating to participation or contribution rules contributions in accordance with section 131(d).

(4) TERMINATION OF PLAN.—Subject to subsection (c), the insurer or organization is ceasing to offer coverage in the small or large group market in a State (or, in the case of a network plan or HMO, in a geographic area).

(5) MOVEMENT OUTSIDE SERVICE AREA.—The employer has changed the place of employment in such manner that employees and dependents reside and are employed outside the service area of the insurer or organization or outside the area for which the insurer or organization is authorized to do business.

(c) EXCEPTIONS FOR UNIFORM TERMINATION OF COVERAGE.—

(1) PARTICULAR TYPE OF COVERAGE NOT OFFERED.—In any case in which a insurer or HMO decides to discontinue offering a particular type of health insurance coverage in the small or large

group market, coverage of such type may be discontinued by the insurer or organization only if—

(A) the insurer or organization provides notice to each employer provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(B) the insurer or organization offers to each employer in the small employer or large employer market provided coverage of this type, the option to purchase any other health insurance coverage currently being offered by the insurer or organization for employers in such market; and

(C) in exercising the option to discontinue coverage of this type and in offering one or more replacement coverage, the insurer or organization acts uniformly without regard to the health status or insurability of participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(2) DISCONTINUANCE OF ALL COVERAGE.—

(A) IN GENERAL.—Subject to subparagraph (C), in any case in which an insurer or HMO elects to discontinue offering all health insurance coverage in the small group market or the large group market, or both markets, in a State, health insurance coverage may be discontinued by the insurer or organization only if—

(i) the insurer or organization provides notice to the applicable State authority and to each employer (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the expiration of such coverage, and

(ii) all health insurance issued or delivered for issuance in the State in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed.

(B) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under subparagraph (A) in one or both markets, the insurer or organization may not provide for the issu-

ance of any health insurance coverage in the market and State involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE.—At the time of coverage renewal, an insurer or HMO may modify the coverage offered to a group health plan in the group health market so long as such modification is effective on a uniform basis among group health plans with that type of coverage.

PART 2—AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE

SEC. 141. GUARANTEED AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE TO CERTAIN INDIVIDUALS WITH PRIOR GROUP COVERAGE.

(a) GOALS.—The goals of this section are—

(1) to guarantee that any qualifying individual (as defined in subsection (b)(1)) is able to obtain qualifying coverage (as defined in subsection (b)(2)); and

(2) to assure that qualifying individuals obtaining such coverage receive credit for their prior coverage toward the new coverage's preexisting condi-

tion exclusion period (if any) in a manner consistent with subsection (b)(3).

(b) QUALIFYING INDIVIDUAL AND HEALTH INSURANCE COVERAGE DEFINED.—In this section—

(1) QUALIFYING INDIVIDUAL.—The term ''qualifying individual'' means an individual—

(A) who is in a qualified coverage period (as defined in section 101(b)(3)(C)) that—

(i) includes coverage under one or more group health plans, and

(ii) commenced 18 or more months before the date on which the individual seeks coverage under this section;

(B) who is not eligible for coverage under a group health plan;

(C) with respect to whom the most recent coverage within the coverage period described in subparagraph (A)(i) was not terminated based on a factor described in paragraph (1) or (2) of section 132(b);

(D) if the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, elected such coverage; and

(E) who, if the individual elected such continuation coverage, has exhausted such continuation coverage.

(2) QUALIFYING COVERAGE.—

(A) IN GENERAL.—The term ''qualifying coverage'' means, with respect to an insurer or HMO in relation to a qualifying individual, individual health insurance coverage for which the actuarial value of the benefits is not less than—

(i) the weighted average actuarial value of the benefits provided by all the individual health insurance coverage issued by the insurer or HMO in the State during the previous year (not including coverage issued under this section), or

(ii) the weighted average of the actuarial value of the benefits provided by all the individual health insurance coverage issued by all insurers and HMOs in the State during the previous year (not including coverage issued under this section),

as elected by the plan or by the State under subsection (c)(1).

(B) ASSUMPTIONS.—For purposes of subparagraph (A), the actuarial value of benefits

provided under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(3) CREDITING FOR PREVIOUS COVERAGE.—Crediting is consistent with this paragraph only if any preexisting condition exclusion period is reduced at least to the extent such a period would be reduced if the coverage under this section were under a group health plan to which section 101(a) applies. In carrying out this subsection, provisions similar to the provisions of section 101(c) shall apply.

(c) OPTIONAL STATE ESTABLISHMENT OF MECHANISMS TO ACHIEVE GOALS OF GUARANTEEING AVAILABILITY OF COVERAGE.—

(1) IN GENERAL.—Any State may establish public or private mechanisms reasonably designed to meet the goals specified in subsection (a). If a State implements such a mechanism by the deadline specified in paragraph (4), the State may elect to have such mechanisms apply instead of having subsection (d) apply in the State. An election under this paragraph shall be by notice to the Secretary of Health and Human Services on a timely basis consistent with the deadlines specified in paragraph (4). In es-

tablishing what is qualifying coverage under such a mechanism under this subsection, a State may exercise the election described in subsection (b)(2)(A) with respect to each insurer or HMO in the State (or on a collective basis after exercising such election for each such insurer or HMO).

(2) TYPES OF MECHANISMS.—State mechanisms under this subsection may include (but are not limited to)—

(A) health insurance coverage pools or programs authorized or established by the State,

(B) mandatory group conversion policies,

(C) guaranteed issue of one or more plans of individual health insurance coverage to qualifying individuals, or

(D) open enrollment by one or more insurers or HMOs.

(3) SAFE HARBOR FOR BENEFITS UNDER CURRENT RISK POOLS.—In the case of a State that has a health insurance coverage pool or risk pool in effect on March 12, 1996, and that implements the mechanism described in paragraph (2)(A), the benefits under such mechanism (or benefits the actuarial value of which is not less than the actuarial value of such current benefits, using the assumptions de-

scribed in subsection (b)(2)(B)) are deemed, for purposes of this section, to constitute qualified coverage.

(4) DEADLINE FOR STATE IMPLEMENTATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the deadline under this paragraph is July 1, 1997.

(B) EXTENSION TO PERMIT LEGISLATION.—The deadline under this paragraph is July 1, 1998, in the case of a State the legislature of which does not have a regular legislative session at any time between January 1, 1997, and June 30, 1997.

(C) CONSTRUCTION.—Nothing in this section shall be construed as preventing a State from—

(i) implementing guaranteed availability mechanisms before the deadline,

(ii) continuing in effect mechanisms that are in effect before the date of the enactment of this Act,

(iii) offering guaranteed availability of coverage that is not qualifying coverage, or

(iv) offering guaranteed availability of coverage to individuals who are not qualifying individuals.

(d) FALLBACK PROVISIONS.—

(1) NO STATE ELECTION.—If a State has not provided notice to the Secretary of an election on a timely basis under subsection (c), the Secretary shall notify the State that paragraph (3) will be applied in the State.

(2) PRELIMINARY DETERMINATION AFTER STATE ELECTION.—If—

(A) a State has provided notice of an election on a timely basis under subsection (c), and

(B) the Secretary finds, after consultation with the chief executive officer of the State and the insurance commissioner or chief insurance regulatory official of the State, that such a mechanism (for which notice was provided) is not reasonably designed to meet the goals specified in subsection (a),

the Secretary shall notify the State of such preliminary determination, of the consequences under paragraph (3) of a failure to implement such a mechanism, and permit the State a reasonable opportunity in which to modify the mechanism (or to adopt another mechanism) that is reasonably designed to meet the goals specified in subsection (a). If, after providing such notice and opportunity, the Secretary

finds that the State has not implemented such a mechanism, the Secretary shall notify the State that paragraph (3) will be applied in the State.

(3) DESCRIPTION OF FALLBACK MECHANISM.—As provided under paragraphs (1) and (2) and subject to paragraph (5), each insurer or HMO in the State involved that issues individual health insurance coverage—

(A) shall offer qualifying health insurance coverage to each qualifying individual in the State, and

(B) may not decline to issue such coverage to such an individual based on health status (except as permitted under paragraph (4)).

(4) APPLICATION OF NETWORK AND CAPACITY LIMITS.—Under regulations, the provisions of subsections (b) and (c) of section 131 shall apply to an individual in the individual health insurance market under this subsection in the same manner as they apply under section 131 to an employer in the small group market.

(5) TERMINATION OF FALLBACK MECHANISM.—The provisions of this subsection shall cease to apply to a State if the Secretary finds that a State has implemented a mechanism that is reasonably designed

to meet the goals specified in subsection (a), and until the Secretary finds that such mechanism is no longer being implemented.

(e) CONSTRUCTION.—

(1) PREMIUMS.—Nothing in this section shall be construed to affect the determination of an insurer or HMO as to the amount of the premium payable under an individual health insurance coverage under applicable state law.

(2) MARKET REQUIREMENTS.—

(A) IN GENERAL.—The provisions of subsection (a) shall not be construed to require that an insurer or HMO offering health insurance coverage only in connection with a group health plan or an association offer individual health insurance coverage.

(B) CONVERSION POLICIES.—An insurer or HMO offering health insurance coverage in connection with a group health plan under subtitle A shall not be deemed to be an insurer or HMO offering an individual health insurance coverage solely because such insurer or HMO offers a conversion policy.

(3) DISREGARD OF ASSOCIATION COVERAGE.—An insurer or HMO that offers health insurance cov-

erage only in connection with a group health plan or in connection with individuals based on affiliation with one or more associations is not considered, for purposes of this subtitle, to be offering individual health insurance coverage.

(4) MARKETING OF PLANS.—Nothing in this section shall be construed to prevent a State from requiring insurer or HMOs offering individual health insurance coverage to actively market such coverage.

SEC. 142. GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

(a) GUARANTEED RENEWABILITY.—Subject to the succeeding provisions of this section, an insurer or HMO that provides individual health insurance coverage to an individual shall renew or continue such coverage at the option of the individual.

(b) NONRENEWAL PERMITTED IN CERTAIN CASES.—An insurer or HMO may nonrenew or discontinue individual health insurance coverage of an individual only based on one or more of the following:

(1) NONPAYMENT.—The individual fails to pay payment of premiums or contributions in accordance with the terms of the coverage or the insurer or organization has not failed to receive timely premium payments.

(2) FRAUD.—The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) TERMINATION OF COVERAGE.—Subject to subsection (c), the insurer or HMO is ceasing to offer health insurance coverage in the individual market in a State (or, in the case of a network plan or HMO, in a geographic area).

(c) TERMINATION OF INDIVIDUAL COVERAGE.—The provisions of section 132(c) shall apply to this section in the same manner as they apply under section 132, except that any reference to an employer or market is deemed a reference to a covered individual or the individual market, respectively.

(d) EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE.—The provisions of section 132(d) shall apply to individual health insurance coverage in the individual market under this section in the same manner as it applies to health insurance coverage offered in connection with a group health plan in the group market under such section.

PART 3—ENFORCEMENT

SEC. 151. INCORPORATION OF PROVISIONS FOR STATE ENFORCEMENT WITH FEDERAL FALLBACK AUTHORITY.

The provisions of paragraphs (1) and (2) of section 104(c) shall apply to enforcement of requirements in each section in part 1 or part 2 with respect to insurers and HMOs regulated by a State in the same manner as such provisions apply to enforcement of requirements in section 101, 102, or 103 with respect to insurers and HMOs regulated by a State.

Subtitle C—Definitions; General Provisions

SEC. 191. DEFINITIONS; SCOPE OF COVERAGE.

(a) GROUP HEALTH PLAN.—

(1) DEFINITION.—Subject to the succeeding provisions of this subsection and subsection (d)(1), the term ''group health plan'' means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in subsection (b)( )) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise, and includes a group health plan (within the meaning of section 5000B(b)(1) of the Internal Revenue Code of 1986).

(2) LIMITATION OF REQUIREMENTS TO PLANS WITH 2 OR MORE EMPLOYEE PARTICIPANTS.—The requirements of subtitle A and part 1 of subtitle B shall apply in the case of a group health plan for any plan year, or for health insurance coverage offered in connection with a group health plan for a year, only if the group health plan has two or more participants as current employees on the first day of the plan year.

(3) EXCLUSION OF PLANS WITH LIMITED COVERAGE.—An employee welfare benefit plan shall be treated as a group health plan under this title only with respect to medical care which is provided under the plan and which does not consist of coverage excluded from the definition of health insurance coverage under subsection (c)(4)(B).

(3) TREATMENT OF CHURCH PLANS.—

(A) EXCLUSION.—The requirements of this title insofar as they apply to group health plans shall not apply to church plans.

(B) OPTIONAL DISREGARD IN DETERMINING PERIOD OF COVERAGE.—For purposes of applying section 101(b)(3)(B)(i), a group health plan may elect to disregard periods of coverage of an individual under a church plan that, pur-

suant to subparagraph (A), is not subject to the requirements of this title.

(4) TREATMENT OF GOVERNMENTAL PLANS.—

(A) ELECTION TO BE EXCLUDED.—If the plan sponsor of a governmental plan which is a group health plan to which the provisions of this subtitle otherwise apply makes an election under this paragraph for any specified period (in such form and manner as the Secretary of Health and Human Services may by regulations prescribe), then the requirements of this title insofar as they apply to group health plans shall not apply to such governmental plans for such period.

(B) OPTIONAL DISREGARD IN DETERMINING PERIOD OF COVERAGE IF ELECTION MADE.—For purposes of applying section 101(b)(3)(B)(i), a group health plan may elect to disregard periods of coverage of an individual under a governmental plan that, under an election under subparagraph (A), is not subject to the requirements of this title.

(5) TREATMENT OF MEDICAID PLAN AS GROUP HEALTH PLAN.—A State plan under title XIX of the Social Security Act shall be treated as a group

health plan for purposes of applying section 101(c), unless the State elects not to be so treated.

(b) INCORPORATION OF CERTAIN DEFINITIONS IN EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—Except as provided in this section, the terms ''beneficiary'', ''church plan'', ''employee'', ''employee welfare benefit plan'', ''employer'', ''governmental plan'', ''multiemployer plan'', ''multiple employer welfare arrangement'', ''participant'', ''plan sponsor'', and ''State'' have the meanings given such terms in section 3 of the Employee Retirement Income Security Act of 1974.

(c) OTHER DEFINITIONS.—For purposes of this title:

(1) APPLICABLE STATE AUTHORITY.—The term ''applicable State authority'' means, with respect to an insurer or health maintenance organization in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State involved with respect to such insurer or organization.

(2) BONA FIDE ASSOCIATION.—The term ''bona fide association'' means an association which—

(A) has been actively in existence for at least 5 years,

(B) has been formed and maintained in good faith for purposes other than obtaining insurance,

(C) does not condition membership in the association on health status,

(D) makes health insurance coverage offered through the association available to all members regardless of health status,

(E) does not make health insurance coverage offered through the association available to any individual who is not a member (or dependent of a member) of the association at the time the coverage is initially issued,

(F) does not impose preexisting condition exclusions except in a manner consistent with the requirements of sections 101 and 102 as they relate to group health plans, and

(G) provides for renewal and continuation of health insurance coverage in a manner consistent with the requirements of section 132 as they relate to the renewal and continuation in force of coverage in a group market.

(3) COBRA CONTINUATION PROVISION.—The term ''COBRA continuation provision'' means any of the following:

(A) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.), other than section 609.

(C) Title XXII of the Public Health Service Act.

(4) HEALTH INSURANCE COVERAGE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term ''health insurance coverage'' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer or a health maintenance organization.

(B) EXCEPTION.—Such term does not include coverage under any separate policy, certificate, or contract only for one or more of any of the following:

(i) Coverage for accident, credit-only, vision, disability income, long-term care, nursing home care, community-based care dental, on-site medical clinics, or employee assistance programs, or any combination thereof.

(ii) Medicare supplemental health insurance (within the meaning of section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1))) and similar supplemental coverage provided under a group health plan.

(iii) Coverage issued as a supplement to liability insurance.

(iv) Liability insurance, including general liability insurance and automobile liability insurance.

(v) Workers' compensation or similar insurance.

(vi) Automobile medical-payment insurance.

(vii) Coverage consisting of benefit payments made on a periodic basis for a specified disease or illness or period of hospitalization, without regard to the costs in-

curred or services rendered during the period to which the payments relate.

(viii) Short-term limited duration insurance.

(ix) Such other coverage, comparable to that described in previous clauses, as may be specified in regulations prescribed under this title.

(5) HEALTH MAINTENANCE ORGANIZATION; HMO.—The terms ''health maintenance organization'' and ''HMO'' mean—

(A) a Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization,

if (other than for purposes of part 2 of subtitle B) it is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974).

(6) HEALTH STATUS.—The term ''health status'' includes, with respect to an individual, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability.

(7) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term ''individual health insurance coverage'' means health insurance coverage offered to individuals if the coverage is not offered in connection with a group health plan (other than such a plan that has fewer than two participants as current employees on the first day of the plan year).

(8) INSURER.—The term ''insurer'' means an insurance company, insurance service, or insurance organization which is licensed to engage in the business of insurance in a State and (except for purposes of part 2 of subtitle B) which is regulated by a State (within the meaning of section 514(b)(2)(A) of the Employee Retirement Income Security Act of 1974).

(9) MEDICAL CARE.—The term ''medical care'' means—

(A) amounts paid for, or items or services in the form of, the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts

paid for, or items or services provided for, the purpose of affecting any structure or function of the body,

(B) amounts paid for, or services in the form of, transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(10) NETWORK PLAN.—The term ''network plan'' means, with respect to health insurance coverage, an arrangement of an insurer or a health maintenance organization under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under contract with the insurer or health maintenance organization.

(11) WAITING PERIOD.—The term ''waiting period'' means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the minimum period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the plan.

(d) TREATMENT OF PARTNERSHIPS.—

(1) TREATMENT AS A GROUP HEALTH PLAN.—Any plan, fund, or program which would not be (but for this paragraph) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, shall be treated (subject to paragraph (1)) as an employee welfare benefit plan which is a group health plan.

(2) TREATMENT OF PARTNERSHIP AND PARTNERS AND EMPLOYER AND PARTICIPANTS.—In the case of a group health plan—

(A) the term ''employer'' includes the partnership in relation to any partner; and

(B) the term ''participant'' includes—

(i) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership, or

(ii) in connection with a group health plan maintained by a self-employed individ-

ual (under which one or more employees are participants), the self-employed individual,

if such individual is or may become eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.

(e) DEFINITIONS RELATING TO MARKETS AND SMALL EMPLOYERS.—As used in this title:

(1) INDIVIDUAL MARKET.—The term ''individual market'' means the market for health insurance coverage offered to individuals and not to employers or in connection with a group health plan and does not include the market for such coverage issued only by an insurer or HMO that makes such coverage available only on the basis of affiliation with an association or other group.

(2) LARGE GROUP MARKET.—The term ''large group market'' means the market for health insurance coverage offered to employers (other than small employers) on behalf of their employees (and their dependents) and does not include health insurance coverage available solely in connection with a bona fide association (as defined in subsection (c)(2)).

(3) SMALL EMPLOYER.—The term ''small employer'' means, in connection with a group health plan with respect to a calendar year, an employer who employs at least 2 but fewer than 51 employees on a typical business day in the year. For purposes of this paragraph, two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group (within the meaning of section 3(40)(B)(ii)).

(4) SMALL GROUP MARKET.—The term ''small group market'' means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) on the basis of employment or other relationship with respect to a small employer and does not include health insurance coverage available solely in connection with a bona fide association (as defined in subsection (c)(2)).

SEC. 192. STATE FLEXIBILITY TO PROVIDE GREATER PROTECTION.

(a) STATE FLEXIBILITY TO PROVIDE GREATER PROTECTION.—Subject to subsection (b), nothing in this title shall be construed to preempt State laws that—

(1) require insurers or HMOs to impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition for a period that is shorter than the applicable period provided for under this title; or

(2) allow individuals, participants, and beneficiaries to be considered to be in a period of previous qualifying coverage if such individual, participant, or beneficiary experiences a lapse in coverage that is greater than the 60-day periods provided for under sections 101(b)(3)(A), 101(b)(3)(B)(ii), and 102(b)(2).

(b) NO OVERRIDE OF ERISA PREEMPTION.—Nothing in this Act shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

SEC. 193. EFFECTIVE DATE.

(a) IN GENERAL.—Except as otherwise provided for in this title, the provisions of this title shall apply with respect to—

(1) group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 1998, and

(2) individual health insurance coverage issued, renewed, in effect, or operated on or after July 1, 1998.

(b) CONSIDERATION OF PREVIOUS COVERAGE.—The Secretaries of Health and Human Services, Treasury, and Labor shall jointly establish rules regarding the treatment (in determining qualified coverage periods under sections 102(b) and 141(b)) of coverage before the applicable effective date specified in subsection (a).

(c) TIMELY ISSUANCE OF REGULATIONS.—The Secretaries of Health and Human Services, the Treasury, and Labor shall issue such regulations on a timely basis as may be required to carry out this title.

SEC. 194. RULE OF CONSTRUCTION.

Nothing in this title or any amendment made thereby may be construed to require the coverage of any specific procedure, treatment, or service as part of a group health plan or health insurance coverage under this title or through regulation.

TITLE II—PREVENTING HEALTH CARE FRAUD AND ABUSE; ADMINISTRATIVE SIMPLIFICATION

SEC. 200. REFERENCES IN TITLE.

Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

Subtitle A—Fraud and Abuse Control Program

SEC. 201. FRAUD AND ABUSE CONTROL PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

''FRAUD AND ABUSE CONTROL PROGRAM

''SEC. 1128C. (a) ESTABLISHMENT OF PROGRAM.—

''(1) IN GENERAL.—Not later than January 1, 1997, the Secretary, acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

"(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to health plans,

"(B) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States,

"(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B and other statutes applicable to health care fraud and abuse,

"(D) to provide for the modification and establishment of safe harbors and to issue advisory opinions and special fraud alerts pursuant to section 1128D, and

"(E) to provide for the reporting and disclosure of certain final adverse actions against health care providers, suppliers, or practitioners pursuant to the data collection system established under section 1128E.

"(2) COORDINATION WITH HEALTH PLANS.—In carrying out the program established under paragraph (1), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of health plans.

''(3) GUIDELINES.—

''(A) IN GENERAL.—The Secretary and the Attorney General shall issue guidelines to carry out the program under paragraph (1). The provisions of sections 553, 556, and 557 of title 5, United States Code, shall not apply in the issuance of such guidelines.

''(B) INFORMATION GUIDELINES.—

''(i) IN GENERAL.—Such guidelines shall include guidelines relating to the furnishing of information by health plans, providers, and others to enable the Secretary and the Attorney General to carry out the program (including coordination with health plans under paragraph (2)).

''(ii) CONFIDENTIALITY.—Such guidelines shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

''(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) (relating to limitation on

liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

''(4) ENSURING ACCESS TO DOCUMENTATION.—The Inspector General of the Department of Health and Human Services is authorized to exercise such authority described in paragraphs (3) through (9) of section 6 of the Inspector General Act of 1978 (5 U.S.C. App.) as necessary with respect to the activities under the fraud and abuse control program established under this subsection.

''(5) AUTHORITY OF INSPECTOR GENERAL.—Nothing in this Act shall be construed to diminish the authority of any Inspector General, including such authority as provided in the Inspector General Act of 1978 (5 U.S.C. App.).

''(b) ADDITIONAL USE OF FUNDS BY INSPECTOR GENERAL.—

''(1) REIMBURSEMENTS FOR INVESTIGATIONS.—The Inspector General of the Department of Health and Human Services is authorized to receive and retain for current use reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans when such costs are

ordered by a court, voluntarily agreed to by the payor, or otherwise.

''(2) CREDITING.—Funds received by the Inspector General under paragraph (1) as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of the deposit of such funds.

''(c) HEALTH PLAN DEFINED.—For purposes of this section, the term 'health plan' means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, and includes—

''(1) a policy of health insurance;

''(2) a contract of a service benefit organization; and

''(3) a membership agreement with a health maintenance organization or other prepaid health plan.''.

(b) ESTABLISHMENT OF HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

''(k) HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—

''(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the 'Health Care Fraud and Abuse Control Account' (in this subsection referred to as the 'Account').

''(2) APPROPRIATED AMOUNTS TO TRUST FUND.—

''(A) IN GENERAL.—There are hereby appropriated to the Trust Fund—

''(i) such gifts and bequests as may be made as provided in subparagraph (B);

''(ii) such amounts as may be deposited in the Trust Fund as provided in sections 242(b) and 249(c) of the Health Coverage Availability and Affordability Act of 1996, and title XI; and

''(iii) such amounts as are transferred to the Trust Fund under subparagraph (C).

''(B) AUTHORIZATION TO ACCEPT GIFTS.—The Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund,

for the benefit of the Account or any activity financed through the Account.

''(C) TRANSFER OF AMOUNTS.—The Managing Trustee shall transfer to the Trust Fund, under rules similar to the rules in section 9601 of the Internal Revenue Code of 1986, an amount equal to the sum of the following:

''(i) Criminal fines recovered in cases involving a Federal health care offense (as defined in section 982(a)(6)(B) of title 18, United States Code).

''(ii) Civil monetary penalties and assessments imposed in health care cases, including amounts recovered under titles XI, XVIII, and XXI, and chapter 38 of title 31, United States Code (except as otherwise provided by law).

''(iii) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

''(iv) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of title 31, United States Code

(known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

''(3) APPROPRIATED AMOUNTS TO ACCOUNT FOR FRAUD AND ABUSE CONTROL PROGRAM, ETC.—

''(A) DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND JUSTICE.—

''(i) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to carry out the purposes described in subparagraph (C), to be available without further appropriation, in an amount not to exceed—

''(I) for fiscal year 1997, $104,000,000, and

''(II) for each of the fiscal years 1998 through 2003, the limit for the preceding fiscal year, increased by 15 percent; and

"(III) for each fiscal year after fiscal year 2003, the limit for fiscal year 2003.

"(ii) MEDICARE AND MEDICAID ACTIVITIES.—For each fiscal year, of the amount appropriated in clause (i), the following amounts shall be available only for the purposes of the activities of the Office of the Inspector General of the Department of Health and Human Services with respect to the medicare and medicaid programs—

"(I) for fiscal year 1997, not less than $60,000,000 and not more than $70,000,000;

"(II) for fiscal year 1998, not less than $80,000,000 and not more than $90,000,000;

"(III) for fiscal year 1999, not less than $90,000,000 and not more than $100,000,000;

"(IV) for fiscal year 2000, not less than $110,000,000 and not more than $120,000,000;

"(V) for fiscal year 2001, not less than $120,000,000 and not more than $130,000,000;

"(VI) for fiscal year 2002, not less than $140,000,000 and not more than $150,000,000; and

"(VII) for each fiscal year after fiscal year 2002, not less than $150,000,000 and not more than $160,000,000.

"(B) FEDERAL BUREAU OF INVESTIGATION.—There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purposes described in subparagraph (C), to be available without further appropriation—

"(i) for fiscal year 1997, $47,000,000;

"(ii) for fiscal year 1998, $56,000,000;

"(iii) for fiscal year 1999, $66,000,000;

"(iv) for fiscal year 2000, $76,000,000;

"(v) for fiscal year 2001, $88,000,000;

"(vi) for fiscal year 2002, $101,000,000; and

"(vii) for each fiscal year after fiscal year 2002, $114,000,000.

"(C) USE OF FUNDS.—The purposes described in this subparagraph are to cover the costs (including equipment, salaries and benefits, and travel and training) of the administration and operation of the health care fraud and abuse control program established under section 1128C(a), including the costs of—

"(i) prosecuting health care matters (through criminal, civil, and administrative proceedings);

"(ii) investigations;

"(iii) financial and performance audits of health care programs and operations;

"(iv) inspections and other evaluations; and

"(v) provider and consumer education regarding compliance with the provisions of title XI.

"(4) APPROPRIATED AMOUNTS TO ACCOUNT FOR MEDICARE INTEGRITY PROGRAM.—

"(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Integrity Program under section 1893, subject to subparagraph (B) and to be available without further appropriation.

"(B) AMOUNTS SPECIFIED.—The amount appropriated under subparagraph (A) for a fiscal year is as follows:

"(i) For fiscal year 1997, such amount shall be not less than $430,000,000 and not more than $440,000,000.

"(ii) For fiscal year 1998, such amount shall be not less than $490,000,000 and not more than $500,000,000.

"(iii) For fiscal year 1999, such amount shall be not less than $550,000,000 and not more than $560,000,000.

''(iv) For fiscal year 2000, such amount shall be not less than $620,000,000 and not more than $630,000,000.

''(v) For fiscal year 2001, such amount shall be not less than $670,000,000 and not more than $680,000,000.

''(vi) For fiscal year 2002, such amount shall be not less than $690,000,000 and not more than $700,000,000.

''(vii) For each fiscal year after fiscal year 2002, such amount shall be not less than $710,000,000 and not more than $720,000,000.

''(5) ANNUAL REPORT.—The Secretary and the Attorney General shall submit jointly an annual report to Congress on the amount of revenue which is generated and disbursed, and the justification for such disbursements, by the Account in each fiscal year.''.

SEC. 202. MEDICARE INTEGRITY PROGRAM.

(a) ESTABLISHMENT OF MEDICARE INTEGRITY PROGRAM.—Title XVIII is amended by adding at the end the following new section:

''MEDICARE INTEGRITY PROGRAM

''SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—There is hereby established the Medicare Integrity Program (in this section referred to as the 'Program') under which the Secretary shall promote the integrity of the medicare program by entering into contracts in accordance with this section with eligible private entities to carry out the activities described in subsection (b).

''(b) ACTIVITIES DESCRIBED.—The activities described in this subsection are as follows:

''(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this title as of the date of the enactment of this section).

''(2) Audit of cost reports.

''(3) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1862(b), and recovery of payments that should not have been made.

''(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

''(5) Developing (and periodically updating) a list of items of durable medical equipment in accordance with section 1834(a)(15) which are subject to prior authorization under such section.

''(c) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if—

''(1) the entity has demonstrated capability to carry out such activities;

''(2) in carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General of the United States, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of such activities;

''(3) the entity demonstrates to the Secretary that the entity's financial holdings, interests, or relationships will not interfere with its ability to perform the functions to be required by the contract in an effective and impartial manner; and

''(4) the entity meets such other requirements as the Secretary may impose.

In the case of the activity described in subsection (b)(5), an entity shall be deemed to be eligible to enter into a contract under the Program to carry out the activity if the entity is a carrier with a contract in effect under section 1842.

''(d) PROCESS FOR ENTERING INTO CONTRACTS.—The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

''(1) The Secretary shall determine the appropriate number of separate contracts which are necessary to carry out the Program and the appropriate times at which the Secretary shall enter into such contracts.

''(2)(A) Except as provided in subparagraph (B), the provisions of section 1153(e)(1) shall apply

to contracts and contracting authority under this section.

''(B) Competitive procedures must be used when entering into new contracts under this section, or at any other time considered appropriate by the Secretary, except that the Secretary may contract with entities that are carrying out the activities described in this section pursuant to agreements under section 1816 or contracts under section 1842 in effect on the date of the enactment of this section.

''(3) A contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

''(e) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.''.

(b) ELIMINATION OF FI AND CARRIER RESPONSIBILITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PROGRAM.—

(1) RESPONSIBILITIES OF FISCAL INTERMEDIARIES UNDER PART A.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

''(l) No agency or organization may carry out (or receive payment for carrying out) any activity pursuant to an agreement under this section to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893.''.

(2) RESPONSIBILITIES OF CARRIERS UNDER PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended by adding at the end the following new paragraph:

''(6) No carrier may carry out (or receive payment for carrying out) any activity pursuant to a contract under this subsection to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).''.

SEC. 203. BENEFICIARY INCENTIVE PROGRAMS.

(a) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—The Secretary

of Health and Human Services (in this section referred to as the ''Secretary'') shall provide an explanation of benefits under the medicare program under title XVIII of the Social Security Act with respect to each item or service for which payment may be made under the program which is furnished to an individual, without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to the item or service.

(b) PROGRAM TO COLLECT INFORMATION ON FRAUD AND ABUSE.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to report to the Secretary information on individuals and entities who are engaging or who have engaged in acts or omissions which constitute grounds for the imposition of a sanction under section 1128, section 1128A, or section 1128B of the Social Security Act, or who have otherwise engaged in fraud and abuse against the medicare program for which there is a sanction provided under law. The program shall discourage provision of, and not consider, information which is frivolous or otherwise

not relevant or material to the imposition of such a sanction.

(2) PAYMENT OF PORTION OF AMOUNTS COLLECTED.—If an individual reports information to the Secretary under the program established under paragraph (1) which serves as the basis for the collection by the Secretary or the Attorney General of any amount of at least $100 (other than any amount paid as a penalty under section 1128B of the Social Security Act), the Secretary may pay a portion of the amount collected to the individual (under procedures similar to those applicable under section 7623 of the Internal Revenue Code of 1986 to payments to individuals providing information on violations of such Code).

(c) PROGRAM TO COLLECT INFORMATION ON PROGRAM EFFICIENCY.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the medicare program.

(2) PAYMENT OF PORTION OF PROGRAM SAVINGS.—If an individual submits a suggestion to the Secretary under the program established under paragraph (1) which is adopted by the Secretary and which results in savings to the program, the Secretary may make a payment to the individual of such amount as the Secretary considers appropriate.

SEC. 204. APPLICATION OF CERTAIN HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO FRAUD AND ABUSE AGAINST FEDERAL HEALTH CARE PROGRAMS.

(a) IN GENERAL.—Section 1128B (42 U.S.C. 1320a–7b) is amended as follows:

(1) In the heading, by striking ''MEDICARE OR STATE HEALTH CARE PROGRAMS'' and inserting ''FEDERAL HEALTH CARE PROGRAMS''.

(2) In subsection (a)(1), by striking ''a program under title XVIII or a State health care program (as defined in section 1128(h))'' and inserting ''a Federal health care program''.

(3) In subsection (a)(5), by striking ''a program under title XVIII or a State health care program'' and inserting ''a Federal health care program''.

(4) In the second sentence of subsection (a)—

(A) by striking ''a State plan approved under title XIX'' and inserting ''a Federal health care program'', and

(B) by striking ''the State may at its option (notwithstanding any other provision of that title or of such plan)'' and inserting ''the administrator of such program may at its option (notwithstanding any other provision of such program)''.

(5) In subsection (b), by striking ''title XVIII or a State health care program'' each place it appears and inserting ''a Federal health care program''.

(6) In subsection (c), by inserting ''(as defined in section 1128(h))'' after ''a State health care program''.

(7) By adding at the end the following new subsection:

''(f) For purposes of this section, the term 'Federal health care program' means—

''(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the

health insurance program under chapter 89 of title 5, United States Code); or

''(2) any State health care program, as defined in section 1128(h).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1997.

SEC. 205. GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS.

Title XI (42 U.S.C. 1301 et seq.), as amended by section 201, is amended by inserting after section 1128C the following new section:

''GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS

''SEC. 1128D. (a) SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.—

''(1) IN GENERAL.—

''(A) SOLICITATION OF PROPOSALS FOR SAFE HARBORS.—Not later than January 1, 1997, and not less than annually thereafter, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

''(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and

Program Protection Act of 1987 (42 U.S.C. 1320a–7b note);

''(ii) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) and shall not serve as the basis for an exclusion under section 1128(b)(7);

''(iii) advisory opinions to be issued pursuant to subsection (b); and

''(iv) special fraud alerts to be issued pursuant to subsection (c).

''(B) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

"(C) REPORT.—The Inspector General of the Department of Health and Human Services (in this section referred to as the 'Inspector General') shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978 (5 U.S.C. App.), describe the proposals received under clauses (i) and (ii) of subparagraph (A) and explain which proposals were included in the publication described in subparagraph (B), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

"(2) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under paragraph (1)(B), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

"(A) An increase or decrease in access to health care services.

"(B) An increase or decrease in the quality of health care services.

"(C) An increase or decrease in patient freedom of choice among health care providers.

"(D) An increase or decrease in competition among health care providers.

"(E) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

"(F) An increase or decrease in the cost to Federal health care programs (as defined in section 1128B(f)).

"(G) An increase or decrease in the potential overutilization of health care services.

"(H) The existence or nonexistence of any potential financial benefit to a health care professional or provider which may vary based on their decisions of—

"(i) whether to order a health care item or service; or

"(ii) whether to arrange for a referral of health care items or services to a particular practitioner or provider.

"(I) Any other factors the Secretary deems appropriate in the interest of preventing fraud

and abuse in Federal health care programs (as so defined).

''(b) ADVISORY OPINIONS.—

''(1) ISSUANCE OF ADVISORY OPINIONS.—The Secretary shall issue written advisory opinions as provided in this subsection.

''(2) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

''(A) What constitutes prohibited remuneration within the meaning of section 1128B(b).

''(B) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1128B(b)(3) for activities which do not result in prohibited remuneration.

''(C) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

''(D) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX or title XXI within the meaning of section 1128B(b).

''(E) Whether any activity or proposed activity constitutes grounds for the imposition of a sanction under section 1128, 1128A, or 1128B.

''(3) MATTERS NOT SUBJECT TO ADVISORY OPINIONS.—Such advisory opinions shall not address the following matters:

''(A) Whether the fair market value shall be, or was paid or received for any goods, services or property.

''(B) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.

''(4) EFFECT OF ADVISORY OPINIONS.—

''(A) BINDING AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

''(B) FAILURE TO SEEK OPINION.—The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A, or 1128B.

''(5) REGULATIONS.—

''(A) IN GENERAL.—Not later than 180 days after the date of the enactment of this section, the Secretary shall issue regulations to carry out this section. Such regulations shall provide for—

''(i) the procedure to be followed by a party applying for an advisory opinion;

''(ii) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

''(iii) the interval in which the Secretary shall respond;

''(iv) the reasonable fee to be charged to the party requesting an advisory opinion; and

''(v) the manner in which advisory opinions will be made available to the public.

''(B) SPECIFIC CONTENTS.—Under the regulations promulgated pursuant to subparagraph (A)—

''(i) the Secretary shall be required to respond to a party requesting an advisory

opinion by not later than 30 days after the request is received; and

"(ii) the fee charged to the party requesting an advisory opinion shall be equal to the costs incurred by the Secretary in responding to the request.

"(c) SPECIAL FRAUD ALERTS.—

"(1) IN GENERAL.—

"(A) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any time, a request to the Inspector General for a notice which informs the public of practices which the Inspector General considers to be suspect or of particular concern under the medicare program or a State health care program, as defined in section 1128(h) (in this subsection referred to as a 'special fraud alert').

"(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—Upon receipt of a request described in subparagraph (A), the Inspector General shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Inspector General shall issue a special fraud alert in response to the request. All

special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

''(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—In determining whether to issue a special fraud alert upon a request described in paragraph (1), the Inspector General may consider—

''(A) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in subsection (a)(2); and

''(B) the volume and frequency of the conduct that would be identified in the special fraud alert.''.

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

SEC. 211. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) INDIVIDUAL CONVICTED OF FELONY RELATING TO HEALTH CARE FRAUD.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a–7(a)) is amended by adding at the end the following new paragraph:

''(3) FELONY CONVICTION RELATING TO HEALTH CARE FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.''.

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 1128(b) (42 U.S.C. 1320a–7(b)) is amended to read as follows:

''(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law—

''(A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzle-

ment, breach of fiduciary responsibility, or other financial misconduct—

"(i) in connection with the delivery of a health care item or service, or

"(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency; or

"(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.".

(b) INDIVIDUAL CONVICTED OF FELONY RELATING TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a–7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

"(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity

that has been convicted after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.''.

(2) CONFORMING AMENDMENT.—Section 1128(b)(3) (42 U.S.C. 1320a–7(b)(3)) is amended—

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

SEC. 212. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

''(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the

Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

''(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

''(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.''.

SEC. 213. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH OWNERSHIP OR CONTROL INTEREST IN SANCTIONED ENTITIES.

Section 1128(b) (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

''(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—(A) Any individual—

''(i) who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know (as defined in section 1128A(i)(6)) of the action constituting the

basis for the conviction or exclusion described in subparagraph (B); or

''(ii) who is an officer or managing employee (as defined in section 1126(b)) of such an entity.

''(B) For purposes of subparagraph (A), the term 'sanctioned entity' means an entity—

''(i) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection; or

''(ii) that has been excluded from participation under a program under title XVIII or under a State health care program.''.

SEC. 214. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is amended by striking ''may prescribe)'' and inserting ''may prescribe, except that such period may not be less than 1 year)''.

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) (42 U.S.C. 1320c–5(b)(2)) is amended by striking ''shall remain'' and inserting ''shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain''.

(b) REPEAL OF ''UNWILLING OR UNABLE'' CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is amended—

(1) in the second sentence, by striking ''and determines'' and all that follows through ''such obligations,''; and

(2) by striking the third sentence.

SEC. 215. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) APPLICATION OF INTERMEDIATE SANCTIONS FOR ANY PROGRAM VIOLATIONS.—

(1) IN GENERAL.—Section 1876(i)(1) (42 U.S.C. 1395mm(i)(1)) is amended by striking ''the Secretary may terminate'' and all that follows and inserting ''in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible or-

ganization if the Secretary determines that the organization—

"(A) has failed substantially to carry out the contract;

"(B) is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; or

"(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).".

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by adding at the end the following new subparagraph:

"(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

"(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

''(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

''(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.''.

(3) PROCEDURES FOR IMPOSING SANCTIONS.—Section 1876(i) (42 U.S.C. 1395mm(i)) is amended by adding at the end the following new paragraph:

''(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(A) the Secretary first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's de-

termination under paragraph (1) and the organization fails to develop or implement such a plan;

''(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an organization has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to the organization's attention;

''(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

''(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.''.

(4) CONFORMING AMENDMENTS.—Section 1876(i)(6)(B) (42 U.S.C. 1395mm(i)(6)(B)) is amended by striking the second sentence.

(b) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—Section 1876(i)(7)(A) (42 U.S.C. 1395mm(i)(7)(A)) is amended by striking ''an agreement'' and inserting ''a written agreement''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1996.

SEC. 216. ADDITIONAL EXCEPTION TO ANTI-KICKBACK PENALTIES FOR DISCOUNTING AND MANAGED CARE ARRANGEMENTS.

(a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) by striking ''and'' at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(F) any remuneration between an organization and an individual or entity providing items or services, or a combination thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1876 or if the written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide, whether through a withhold, capitation, incentive pool, per

diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to written agreements entered into on or after January 1, 1997.

SEC. 217. CRIMINAL PENALTY FOR FRAUDULENT DISPOSITION OF ASSETS IN ORDER TO OBTAIN MEDICAID BENEFITS.

Section 1128B(a) (42 U.S.C. 1320a–7b(a)) is amended—

(1) by striking ''or'' at the end of paragraph (4);

(2) by adding ''or'' at the end of paragraph (5); and

(3) by inserting after paragraph (5) the following new paragraph:

''(6) knowingly and willfully disposes of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c),''.

SEC. 218. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this subtitle shall take effect January 1, 1997.

Subtitle C—Data Collection

SEC. 221. ESTABLISHMENT OF THE HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.

(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.), as amended by sections 211 and 215, is amended by inserting after section 1128D the following new section:

"HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM

"SEC. 1128E. (a) GENERAL PURPOSE.—Not later than January 1, 1997, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (c).

"(b) REPORTING OF INFORMATION.—

"(1) IN GENERAL.—Each Government agency and health plan shall report any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner.

''(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) includes:

''(A) The name and TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

''(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner is affiliated or associated.

''(C) The nature of the final adverse action and whether such action is on appeal.

''(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.

''(3) CONFIDENTIALITY.—In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

''(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

''(5) TO WHOM REPORTED.—The information required to be reported under this subsection shall be reported to the Secretary.

''(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

''(1) DISCLOSURE.—With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the Secretary under this section respecting a health care provider, supplier, or practitioner, the Secretary shall, by regulation, provide for—

''(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

''(B) procedures in the case of disputed accuracy of the information.

''(2) CORRECTIONS.—Each Government agency and health plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

''(d) ACCESS TO REPORTED INFORMATION.—

''(1) AVAILABILITY.—The information in this database shall be available to Federal and State government agencies and health plans pursuant to procedures that the Secretary shall provide by regulation.

''(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in this database (other than with respect to requests by Federal agencies). The amount of such a fee shall be sufficient to recover the full costs of operating the database. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs.

''(e) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including the agency designated by the Secretary in subsection (b)(5) shall be held liable in any civil action with respect to any report made

as required by this section, without knowledge of the falsity of the information contained in the report.

''(f) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

''(1) FINAL ADVERSE ACTION.—

''(A) IN GENERAL.—The term 'final adverse action' includes:

''(i) Civil judgments against a health care provider, supplier, or practitioner in Federal or State court related to the delivery of a health care item or service.

''(ii) Federal or State criminal convictions related to the delivery of a health care item or service.

''(iii) Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

''(I) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation,

''(II) any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or

''(III) any other negative action or finding by such Federal or State agency that is publicly available information.

''(iv) Exclusion from participation in Federal or State health care programs.

''(v) Any other adjudicated actions or decisions that the Secretary shall establish by regulation.

''(B) EXCEPTION.—The term does not include any action with respect to a malpractice claim.

''(2) PRACTITIONER.—The terms 'licensed health care practitioner', 'licensed practitioner', and 'practitioner' mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

''(3) GOVERNMENT AGENCY.—The term 'Government agency' shall include:

''(A) The Department of Justice.

''(B) The Department of Health and Human Services.

''(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the Veterans' Administration.

''(D) State law enforcement agencies.

''(E) State medicaid fraud control units.

''(F) Federal or State agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.

''(4) HEALTH PLAN.—The term 'health plan' has the meaning given such term by section 1128C(c).

''(5) DETERMINATION OF CONVICTION.—For purposes of paragraph (1), the existence of a conviction shall be determined under paragraph (4) of section 1128(i).''.

(b) IMPROVED PREVENTION IN ISSUANCE OF MEDICARE PROVIDER NUMBERS.—Section 1842(r) (42 U.S.C. 1395u(r)) is amended by adding at the end the following

new sentence: ''Under such system, the Secretary may impose appropriate fees on such physicians to cover the costs of investigation and recertification activities with respect to the issuance of the identifiers.''.

Subtitle D—Civil Monetary Penalties

SEC. 231. SOCIAL SECURITY ACT CIVIL MONETARY PENALTIES.

(a) GENERAL CIVIL MONETARY PENALTIES.—Section 1128A (42 U.S.C. 1320a–7a) is amended as follows:

(1) In the third sentence of subsection (a), by striking ''programs under title XVIII'' and inserting ''Federal health care programs (as defined in section 1128B(f)(1))''.

(2) In subsection (f)—

(A) by redesignating paragraph (3) as paragraph (4); and

(B) by inserting after paragraph (2) the following new paragraph:

''(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128B(f)), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts

recovered under this section by reason of the amendments made by the Health Coverage Availability and Affordability Act of 1996 (as estimated by the Secretary) shall be deposited into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C).''.

(3) In subsection (i)—

(A) in paragraph (2), by striking ''title V, XVIII, XIX, or XX of this Act'' and inserting ''a Federal health care program (as defined in section 1128B(f))'',

(B) in paragraph (4), by striking ''a health insurance or medical services program under title XVIII or XIX of this Act'' and inserting ''a Federal health care program (as so defined)'', and

(C) in paragraph (5), by striking ''title V, XVIII, XIX, or XX'' and inserting ''a Federal health care program (as so defined)''.

(4) By adding at the end the following new subsection:

''(m)(1) For purposes of this section, with respect to a Federal health care program not contained in this Act, references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the

department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

''(2)(A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

''(i) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

''(ii) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

''(B) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 with respect to the claims submitted to the other depart-

ments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.''.

(b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP OR CONTROL INTEREST IN PARTICIPATING ENTITY.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(1) by striking ''or'' at the end of paragraph (1)(D);

(2) by striking '', or'' at the end of paragraph (2) and inserting a semicolon;

(3) by striking the semicolon at the end of paragraph (3) and inserting ''; or''; and

(4) by inserting after paragraph (3) the following new paragraph:

''(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection—

''(i) retains a direct or indirect ownership or control interest in an entity that is participating in a program under title XVIII or a State health care program, and who knows or

should know of the action constituting the basis for the exclusion; or

''(ii) is an officer or managing employee (as defined in section 1126(b)) of such an entity;''.

(c) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by subsection (b), is amended in the matter following paragraph (4)—

(1) by striking ''$2,000'' and inserting ''$10,000'';

(2) by inserting ''; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs'' after ''false or misleading information was given''; and

(3) by striking ''twice the amount'' and inserting ''3 times the amount''.

(d) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING OR MEDICALLY UNNECESSARY SERVICES.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1)) is amended—

(1) in subparagraph (A) by striking ''claimed,'' and inserting ''claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or serv-

ice that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,'';

(2) in subparagraph (C), by striking ''or'' at the end;

(3) in subparagraph (D), by striking ''; or'' and inserting '', or''; and

(4) by inserting after subparagraph (D) the following new subparagraph:

''(E) is for a medical or other item or service that a person knows or should know is not medically necessary; or''.

(e) SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.—Section 1156(b)(3) (42 U.S.C. 1320c–5(b)(3)) is amended by striking ''the actual or estimated cost'' and inserting ''up to $10,000 for each instance''.

(f) PROCEDURAL PROVISIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)), as amended by section 215(a)(2), is amended by adding at the end the following new subparagraph:

''(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money pen-

alty under subparagraph (B)(i) or (C)(i) in the same manner as such provisions apply to a civil money penalty or proceeding under section 1128A(a).''.

(g) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR PLANS.—

(1) OFFER OF REMUNERATION.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(A) by striking ''or'' at the end of paragraph (1)(D);

(B) by striking '', or'' at the end of paragraph (2) and inserting a semicolon;

(C) by striking the semicolon at the end of paragraph (3) and inserting ''; or''; and

(D) by inserting after paragraph (3) the following new paragraph:

''(4) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title

XVIII, or a State health care program (as so defined);''.

(2) REMUNERATION DEFINED.—Section 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by adding the following new paragraph:

''(6) The term 'remuneration' includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term 'remuneration' does not include—

''(A) the waiver of coinsurance and deductible amounts by a person, if—

''(i) the waiver is not offered as part of any advertisement or solicitation;

''(ii) the person does not routinely waive coinsurance or deductible amounts; and

''(iii) the person—

''(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need;

''(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

"(III) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;

"(B) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996; or

"(C) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated.".

(h) EFFECTIVE DATE.—The amendments made by this section shall take effect January 1, 1997.

SEC. 232. CLARIFICATION OF LEVEL OF INTENT REQUIRED FOR IMPOSITION OF SANCTIONS.

(a) CLARIFICATION OF LEVEL OF KNOWLEDGE REQUIRED FOR IMPOSITION OF CIVIL MONETARY PENALTIES.—

(1) IN GENERAL.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(A) in paragraphs (1) and (2), by inserting ''knowingly'' before ''presents'' each place it appears; and

(B) in paragraph (3), by striking ''gives'' and inserting ''knowingly gives or causes to be given''.

(2) DEFINITION OF STANDARD.—Section 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by adding at the end the following new paragraph:

''(6) The term 'should know' means that a person, with respect to information—

''(A) acts in deliberate ignorance of the truth or falsity of the information; or

''(B) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to acts or omissions occurring on or after January 1, 1997.

SEC. 233. PENALTY FOR FALSE CERTIFICATION FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1128A(b) (42 U.S.C. 1320a–7a(b)) is amended by adding at the end the following new paragraph:

''(3)(A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of—

''(i) $5,000, or

''(ii) three times the amount of the payments under title XVIII for home health services which are made pursuant to such certification.

''(B) A document described in this subparagraph is any document that certifies, for purposes of title XVIII, that an individual meets the requirements of section 1814(a)(2)(C) or 1835(a)(2)(A) in the case of home health services furnished to the individual.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to certifications made on or after the date of the enactment of this Act.

Subtitle E—Revisions to Criminal Law

SEC. 241. DEFINITION OF FEDERAL HEALTH CARE OFFENSE.

(a) IN GENERAL.—Chapter 1 of title 18, United States Code, is amended by adding at the end the following:

"§ 24. Definition of Federal health care offense

''(a) As used in this title, the term 'Federal health care offense' means a violation of, or a criminal conspiracy to violate—

''(1) section 669, 1035, or 1347 of this title; or

''(2) section 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of this title, if the violation or conspiracy relates to a health care benefit program.

''(b) As used in this title, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 2 of title 18, United States Code, is amended by inserting after the item relating to section 23 the following new item:

''24. Definition relating to Federal health care offense defined.''.

SEC. 242. HEALTH CARE FRAUD.

(a) OFFENSE.—

(1) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"§ 1347. Health care fraud

''(a) Whoever knowingly executes, or attempts to execute, a scheme or artifice—

''(1) to defraud any health care benefit program; or

''(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program,

in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title), such person shall be fined under this title or imprisoned not more than 20 years, or both; and if the violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.

''(b) As used in this section, the term 'health care benefit program' means any public or private plan or contract, affecting commerce, under which any medical bene-

fit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''1347. Health care fraud.''.

(b) CRIMINAL FINES DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—The Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act (42 U.S.C. 1395i) an amount equal to the criminal fines imposed under section 1347 of title 18, United States Code (relating to health care fraud).

SEC. 243. THEFT OR EMBEZZLEMENT.

(a) IN GENERAL.—Chapter 31 of title 18, United States Code, is amended by adding at the end the following:

''§ 669. Theft or embezzlement in connection with health care

''(a) Whoever embezzles, steals, or otherwise without authority willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums,

credits, property, or other assets of a health care benefit program, shall be fined under this title or imprisoned not more than 10 years, or both; but if the value of such property does not exceed the sum of $100 the defendant shall be fined under this title or imprisoned not more than one year, or both.

''(b) As used in this section, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 31 of title 18, United States Code, is amended by adding at the end the following:

''669. Theft or embezzlement in connection with health care.''.

SEC. 244. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 47 of title 18, United States Code, is amended by adding at the end the following:

''§ 1035. False statements relating to health care matters

''(a) Whoever, in any matter involving a health care benefit program, knowingly—

''(1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or

''(2) makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to con-

tain any false, fictitious, or fraudulent statement or entry,

in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) As used in this section, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, is amended by adding at the end the following new item:

''1035. False statements relating to health care matters.''.

SEC. 245. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF HEALTH CARE OFFENSES.

(a) IN GENERAL.—Chapter 73 of title 18, United States Code, is amended by adding at the end the following:

''§ 1518. Obstruction of criminal investigations of health care offenses

''(a) Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a Federal health care offense to a criminal investigator shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) As used in this section the term 'criminal investigator' means any individual duly authorized by a department, agency, or armed force of the United States to conduct or engage in investigations for prosecutions for violations of health care offenses.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 of title 18, United States Code, is amended by adding at the end the following new item:

''1518. Obstruction of criminal investigations of health care offenses.''.

SEC. 246. LAUNDERING OF MONETARY INSTRUMENTS.

Section 1956(c)(7) of title 18, United States Code, is amended by adding at the end the following:

''(F) Any act or activity constituting an offense involving a Federal health care offense.''.

SEC. 247. INJUNCTIVE RELIEF RELATING TO HEALTH CARE OFFENSES.

(a) IN GENERAL.—Section 1345(a)(1) of title 18, United States Code, is amended—

(1) by striking ''or'' at the end of subparagraph (A);

(2) by inserting ''or'' at the end of subparagraph (B); and

(3) by adding at the end the following:

''(C) committing or about to commit a Federal health care offense.''.

(b) FREEZING OF ASSETS.—Section 1345(a)(2) of title 18, United States Code, is amended by inserting ''or a Federal health care offense''.

SEC. 248. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

(a) IN GENERAL.—Chapter 233 of title 18, United States Code, is amended by adding after section 3485 the following:

''§ 3486. Authorized investigative demand procedures

''(a) AUTHORIZATION.—In any investigation relating to any act or activity involving a Federal health care offense, the Attorney General or the Attorney General's designee may issue in writing and cause to be served a subpoena requiring the production of any records (including any books, papers, documents, electronic media, or other objects or tangible things), which may be relevant to an authorized law enforcement inquiry, that a person or legal entity may possess or have care, custody, or control. A subpoena shall describe the objects required to be produced and prescribe a return date within a reasonable period of time within which the objects can be assembled and made available.

''(b) SERVICE.—A subpoena issued under this section may be served by any person designated in the subpoena to serve it. Service upon a natural person may be made

by personal delivery of the subpoena to him. Service may be made upon a domestic or foreign corporation or upon a partnership or other unincorporated association which is subject to suit under a common name, by delivering the subpoena to an officer, to a managing or general agent, or to any other agent authorized by appointment or by law to receive service of process. The affidavit of the person serving the subpoena entered on a true copy thereof by the person serving it shall be proof of service.

''(c) ENFORCEMENT.—In the case of contumacy by or refusal to obey a subpoena issued to any person, the Attorney General may invoke the aid of any court of the United States within the jurisdiction of which the investigation is carried on or of which the subpoenaed person is an inhabitant, or in which he carries on business or may be found, to compel compliance with the subpoena. The court may issue an order requiring the subpoenaed person to appear before the Attorney General to produce records, if so ordered, or to give testimony touching the matter under investigation. Any failure to obey the order of the court may be punished by the court as a contempt thereof. All process in any such case may be served in any judicial district in which such person may be found.

''(d) IMMUNITY FROM CIVIL LIABILITY.—Notwithstanding any Federal, State, or local law, any person, in-

cluding officers, agents, and employees, receiving a summons under this section, who complies in good faith with the summons and thus produces the materials sought, shall not be liable in any court of any State or the United States to any customer or other person for such production or for nondisclosure of that production to the customer.

''(e) LIMITATION ON USE.—(1) Health information about an individual that is disclosed under this section may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information unless the action or investigation arises out of and is directly related to receipt of health care or payment for health care or action involving a fraudulent claim related to health; or if authorized by an appropriate order of a court of competent jurisdiction, granted after application showing good cause therefor.

''(2) In assessing good cause, the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.

''(3) Upon the granting of such order, the court, in determining the extent to which any disclosure of all or

any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 223 of title 18, United States Code, is amended by inserting after the item relating to section 3485 the following new item:

''3486. Authorized investigative demand procedures.''.

(c) CONFORMING AMENDMENT.—Section 1510(b)(3)(B) of title 18, United States Code, is amended by inserting ''or a Department of Justice subpoena (issued under section 3486 of title 18),'' after ''subpoena''.

SEC. 249. FORFEITURES FOR FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Section 982(a) of title 18, United States Code, is amended by adding after paragraph (5) the following new paragraph:

''(6) The court, in imposing sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.''.

(b) CONFORMING AMENDMENT.—Section 982(b)(1)(A) of title 18, United States Code, is amended by inserting ''or (a)(6)'' after ''(a)(1)''.

(c) PROPERTY FORFEITED DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—

(1) IN GENERAL.—After the payment of the costs of asset forfeiture has been made, and notwithstanding any other provision of law, the Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act, as added by section 301(b), an amount equal to the net amount realized from the forfeiture of property by reason of a Federal health care offense pursuant to section 982(a)(6) of title 18, United States Code.

(2) COSTS OF ASSET FORFEITURE.—For purposes of paragraph (1), the term ''payment of the costs of asset forfeiture'' means—

(A) the payment, at the discretion of the Attorney General, of any expenses necessary to seize, detain, inventory, safeguard, maintain, advertise, sell, or dispose of property under seizure, detention, or forfeited, or of any other necessary expenses incident to the seizure, detention, forfeiture, or disposal of such property, including payment for—

(i) contract services,

(ii) the employment of outside contractors to operate and manage properties or provide other specialized services nec-

essary to dispose of such properties in an effort to maximize the return from such properties; and

(iii) reimbursement of any Federal, State, or local agency for any expenditures made to perform the functions described in this subparagraph;

(B) at the discretion of the Attorney General, the payment of awards for information or assistance leading to a civil or criminal forfeiture involving any Federal agency participating in the Health Care Fraud and Abuse Control Account;

(C) the compromise and payment of valid liens and mortgages against property that has been forfeited, subject to the discretion of the Attorney General to determine the validity of any such lien or mortgage and the amount of payment to be made, and the employment of attorneys and other personnel skilled in State real estate law as necessary;

(D) payment authorized in connection with remission or mitigation procedures relating to property forfeited; and

(E) the payment of State and local property taxes on forfeited real property that accrued between the date of the violation giving rise to the forfeiture and the date of the forfeiture order.

Subtitle F—Administrative Simplification

SEC. 251. PURPOSE.

It is the purpose of this subtitle to improve the medicare program under title XVIII of the Social Security Act, the medicaid program under title XIX of such Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.

SEC. 252. ADMINISTRATIVE SIMPLIFICATION.

(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.) is amended by adding at the end the following:

"PART C—ADMINISTRATIVE SIMPLIFICATION

"SEC. 1171. DEFINITIONS.

''For purposes of this part:

''(1) CLEARINGHOUSE.—The term 'clearinghouse' means a public or private entity that—

"(A) processes or facilitates the processing of nonstandard data elements of health information into standard data elements; or

"(B) provides the means by which persons may meet the requirements of this part.

"(2) CODE SET.—The term 'code set' means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

"(3) COORDINATION OF BENEFITS.—The term 'coordination of benefits' means determining and coordinating the financial obligations of health plans when health care benefits are payable under 2 or more health plans.

"(4) HEALTH CARE PROVIDER.—The term 'health care provider' includes a provider of services (as defined in section 1861(u)), a provider of medical or other health services (as defined in section 1861(s)), and any other person furnishing health care services or supplies.

"(5) HEALTH INFORMATION.—The term 'health information' means any information, whether oral or recorded in any form or medium that—

"(A) is created or received by a health care provider, health plan, public health authority,

employer, life insurer, school or university, or clearinghouse; and

"(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

"(6) HEALTH PLAN.—The term 'health plan' means a plan which provides, or pays the cost of, health benefits. Such term includes the following, or any combination thereof:

"(A) Part A or part B of the medicare program under title XVIII.

"(B) The medicaid program under title XIX.

"(C) A medicare supplemental policy (as defined in section 1882(g)(1)).

"(D) Coverage issued as a supplement to liability insurance.

"(E) General liability insurance.

"(F) Worker's compensation or similar insurance.

"(G) Automobile or automobile medical-payment insurance.

"(H) A long-term care policy, including a nursing home fixed indemnity policy (unless the Secretary determines that such a policy does not provide sufficiently comprehensive coverage of a benefit so that the policy should be treated as a health plan).

"(I) A hospital or fixed indemnity income-protection policy.

"(J) An employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)), but only to the extent the plan is established or maintained for the purpose of providing health benefits and has 50 or more participants (as defined in section 3(7) of such Act).

"(K) An employee welfare benefit plan or any other arrangement which is established or maintained for the purpose of offering or providing health benefits to the employees of 2 or more employers.

"(L) The health care program for active military personnel under title 10, United States Code.

''(M) The veterans health care program under chapter 17 of title 38, United States Code.

''(N) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1073(4) of title 10, United States Code.

''(O) The Indian health service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(P) The Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code.

''(Q) Such other plan or arrangement as the Secretary determines is a health plan.

''(7) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term 'individually identifiable health information' means any information, including demographic information collected from an individual, that—

''(A) is created or received by a health care provider, health plan, employer, or clearinghouse; and

''(B) relates to the past, present, or future physical or mental health or condition of an in-

dividual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and—

"(i) identifies an individual; or

"(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify an individual.

"(8) STANDARD.—The term 'standard', when used with reference to a data element of health information or a transaction referred to in section 1173(a)(1), means any such data element or transaction that meets each of the standards and implementation specifications adopted or established by the Secretary with respect to the data element or transaction under sections 1172 and 1173.

"(9) STANDARD SETTING ORGANIZATION.—The term 'standard setting organization' means a standard setting organization accredited by the American National Standards Institute, including the National Council for Prescription Drug Programs, that develops standards for information transactions, data elements, or any other standard that is necessary to, or will facilitate, the implementation of this part.

"SEC. 1172. GENERAL REQUIREMENTS FOR ADOPTION OF STANDARDS.

"(a) APPLICABILITY.—Any standard or modification of a standard adopted under this part shall apply to the following persons:

"(1) A health plan.

"(2) A clearinghouse.

"(3) A health care provider who transmits any health information in electronic form in connection with a transaction referred to in section 1173(a)(1).

"(b) REDUCTION OF COSTS.—Any standard or modification of a standard adopted under this part shall be consistent with the objective of reducing the administrative costs of providing and paying for health care.

"(c) ROLE OF STANDARD SETTING ORGANIZATIONS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), any standard or modification of a standard adopted under this part shall be developed or modified by a standard setting organization.

"(2) SPECIAL RULE.—The Secretary may adopt a standard or modification of a standard that is different from any standard developed or modified by a standard setting organization, if—

"(A) the different standard or modification will substantially reduce administrative costs to

health care providers and health plans compared to the alternatives; and

''(B) the standard or modification is promulgated in accordance with the rulemaking procedures of subchapter III of chapter 5 of title 5, United States Code.

''(d) IMPLEMENTATION SPECIFICATIONS.—The Secretary shall establish specifications for implementing each of the standards and modifications adopted under this part.

''(e) PROTECTION OF TRADE SECRETS.—Except as otherwise required by law, a standard or modification of a standard adopted under this part shall not require disclosure of trade secrets or confidential commercial information by a person required to comply with this part.

''(f) ASSISTANCE TO THE SECRETARY.—In complying with the requirements of this part, the Secretary shall rely on the recommendations of the Health Information Advisory Committee established under section 1179 and shall consult with appropriate Federal and State agencies and private organizations. The Secretary shall publish in the Federal Register the recommendations of the Health Information Advisory Committee regarding the adoption of a standard or modification of a standard under this part.

"SEC. 1173. STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS.

"(a) STANDARDS TO ENABLE ELECTRONIC EXCHANGE.—

"(1) IN GENERAL.—The Secretary shall adopt standards for transactions, and data elements for such transactions, to enable health information to be exchanged electronically, that are—

"(A) appropriate for the financial and administrative transactions described in paragraph (2); and

"(B) related to other financial and administrative transactions determined appropriate by the Secretary consistent with the goals of improving the operation of the health care system and reducing administrative costs.

"(2) TRANSACTIONS.—The transactions referred to in paragraph (1)(A) are the following:

"(A) Claims (including coordination of benefits) or equivalent encounter information.

"(B) Claims attachments.

"(C) Enrollment and disenrollment.

"(D) Eligibility.

"(E) Health care payment and remittance advice.

"(F) Premium payments.

''(G) First report of injury.

''(H) Claims status.

''(I) Referral certification and authorization.

''(3) ACCOMMODATION OF SPECIFIC PROVIDERS.—The standards adopted by the Secretary under paragraph (1) shall accommodate the needs of different types of health care providers.

''(b) UNIQUE HEALTH IDENTIFIERS.—

''(1) IN GENERAL.—The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system. In carrying out the preceding sentence for each health plan and health care provider, the Secretary shall take into account multiple uses for identifiers and multiple locations and specialty classifications for health care providers.

''(2) USE OF IDENTIFIERS.—The standards adopted under paragraphs (1) shall specify the purposes for which a unique health identifier may be used.

''(c) CODE SETS.—

''(1) IN GENERAL.—The Secretary shall adopt standards that—

''(A) select code sets for appropriate data elements for the transactions referred to in subsection (a)(1) from among the code sets that have been developed by private and public entities; or

''(B) establish code sets for such data elements if no code sets for the data elements have been developed.

''(2) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution (including electronic distribution) of code sets and modifications made to such code sets under section 1174(b).

''(d) SECURITY STANDARDS FOR HEALTH INFORMATION.—

''(1) SECURITY STANDARDS.—The Secretary shall adopt security standards that—

''(A) take into account—

''(i) the technical capabilities of record systems used to maintain health information;

''(ii) the costs of security measures;

''(iii) the need for training persons who have access to health information;

''(iv) the value of audit trails in computerized record systems; and

''(v) the needs and capabilities of small health care providers and rural health care providers (as such providers are defined by the Secretary); and

''(B) ensure that a clearinghouse, if it is part of a larger organization, has policies and security procedures which isolate the activities of the clearinghouse with respect to processing information in a manner that prevents unauthorized access to such information by such larger organization.

''(2) SAFEGUARDS.—Each person described in section 1172(a) who maintains or transmits health information shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

''(A) to ensure the integrity and confidentiality of the information;

''(B) to protect against any reasonably anticipated—

''(i) threats or hazards to the security or integrity of the information; and

''(ii) unauthorized uses or disclosures of the information; and

''(C) otherwise to ensure compliance with this part by the officers and employees of such person.

''(e) PRIVACY STANDARDS FOR HEALTH INFORMATION.—The Secretary shall adopt standards with respect to the privacy of individually identifiable health information. Such standards shall include standards concerning at least the following:

''(1) The rights of an individual who is a subject of such information.

''(2) The procedures to be established for the exercise of such rights.

''(3) The uses and disclosures of such information that are authorized or required.

''(f) ELECTRONIC SIGNATURE.—

''(1) IN GENERAL.—The Secretary, in coordination with the Secretary of Commerce, shall adopt standards specifying procedures for the electronic transmission and authentication of signatures, compliance with which shall be deemed to satisfy Federal and State statutory requirements for written signatures with respect to the transactions referred to in subsection (a)(1).

''(2) PAYMENTS FOR SERVICES AND PREMIUMS.—Nothing in this part shall be construed to prohibit payment for health care services or health plan premiums by debit, credit, payment card or numbers, or other electronic means.

''(g) COORDINATION OF BENEFITS.—The Secretary shall adopt standards—

''(1) for determining the financial liability of health plans when health care benefits are payable under two or more health plans; and

''(2) for transferring among health plans appropriate standard data elements needed for the coordination of benefits, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

''SEC. 1174. TIMETABLES FOR ADOPTION OF STANDARDS.

''(a) INITIAL STANDARDS.—The Secretary shall carry out section 1173 not later than 18 months after the date of the enactment of this part, except that standards relating to claims attachments shall be adopted not later than 30 months after such date.

''(b) ADDITIONS AND MODIFICATIONS TO STANDARDS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards

adopted under section 1173, and shall adopt additional or modified standards, as determined appropriate, but not more frequently than once every 6 months. Any addition or modification to a standard shall be completed in a manner which minimizes the disruption and cost of compliance.

''(2) SPECIAL RULES.—

''(A) FIRST 12-MONTH PERIOD.—Except with respect to additions and modifications to code sets under subparagraph (B), the Secretary may not adopt any modification to a standard adopted under this part during the 12-month period beginning on the date the standard is initially adopted, unless the Secretary determines that the modification is necessary in order to permit compliance with the standard.

''(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

''(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

''(ii) ADDITIONAL RULES.—If a code set is modified under this subsection, the

modified code set shall include instructions on how data elements of health information that were encoded prior to the modification may be converted or translated so as to preserve the informational value of the data elements that existed before the modification. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption and cost of complying with such modification.

"SEC. 1175. REQUIREMENTS.

''(a) CONDUCT OF TRANSACTIONS BY PLANS.—

''(1) IN GENERAL.—If a person desires to conduct a transaction referred to in section 1173(a)(1) with a health plan as a standard transaction—

''(A) the health plan may not refuse to conduct such transaction as a standard transaction;

''(B) the health plan may not delay such transaction, or otherwise adversely affect, or attempt to adversely affect, the person or the transaction on the ground that the transaction is a standard transaction; and

"(C) the information transmitted and received in connection with the transaction shall be in the form of standard data elements of health information.

"(2) SATISFACTION OF REQUIREMENTS.—A health plan may satisfy the requirements under paragraph (1) by—

"(A) directly transmitting and receiving standard data elements of health information; or

"(B) submitting nonstandard data elements to a clearinghouse for processing into standard data elements and transmission by the clearinghouse, and receiving standard data elements through the clearinghouse.

"(3) TIMETABLE FOR COMPLIANCE.—Paragraph (1) shall not be construed to require a health plan to comply with any standard, implementation specification, or modification to a standard or specification adopted or established by the Secretary under sections 1172 and 1173 at any time prior to the date on which the plan is required to comply with the standard or specification under subsection (b).

"(b) COMPLIANCE WITH STANDARDS.—

''(1) INITIAL COMPLIANCE.—

''(A) IN GENERAL.—Not later than 24 months after the date on which an initial standard or implementation specification is adopted or established under sections 1172 and 1173, each person to whom the standard or implementation specification applies shall comply with the standard or specification.

''(B) SPECIAL RULE FOR SMALL HEALTH PLANS.—In the case of a small health plan, paragraph (1) shall be applied by substituting ''36 months'' for ''24 months''. For purposes of this subsection, the Secretary shall determine the plans that qualify as small health plans.

''(2) COMPLIANCE WITH MODIFIED STANDARDS.—If the Secretary adopts a modification to a standard or implementation specification under this part, each person to whom the standard or implementation specification applies shall comply with the modified standard or implementation specification at such time as the Secretary determines appropriate, taking into account the time needed to comply due to the nature and extent of the modification. The time determined appropriate under the preceding sentence may not be earlier than the last day of the

180-day period beginning on the date such modification is adopted. The Secretary may extend the time for compliance for small health plans, if the Secretary determines that such extension is appropriate.

"SEC. 1176. GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS.

"(a) GENERAL PENALTY.—

"(1) IN GENERAL.—Except as provided in subsection (b), the Secretary shall impose on any person who violates a provision of this part a penalty of not more than $100 for each such violation, except that the total amount imposed on the person for all violations of an identical requirement or prohibition during a calendar year may not exceed $25,000.

"(2) PROCEDURES.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this subsection in the same manner as such provisions apply to the imposition of a penalty under such section 1128A.

"(b) LIMITATIONS.—

"(1) OFFENSES OTHERWISE PUNISHABLE.—A penalty may not be imposed under subsection (a)

with respect to an act if the act constitutes an offense punishable under section 1177.

''(2) NONCOMPLIANCE NOT DISCOVERED.—A penalty may not be imposed under subsection (a) with respect to a provision of this part if it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person violated the provision.

''(3) FAILURES DUE TO REASONABLE CAUSE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), a penalty may not be imposed under subsection (a) if—

''(i) the failure to comply was due to reasonable cause and not to willful neglect; and

''(ii) the failure to comply is corrected during the 30-day period beginning on the 1st date the person liable for the penalty knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

''(B) EXTENSION OF PERIOD.—

''(i) NO PENALTY.—The period referred to in subparagraph (A)(ii) may be

extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

''(ii) ASSISTANCE.—If the Secretary determines that a person failed to comply because the person was unable to comply, the Secretary may provide technical assistance to the person during the period described in subparagraph (A)(ii). Such assistance shall be provided in any manner determined appropriate by the Secretary.

''(4) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under subsection (a) that is not entirely waived under paragraph (3) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

''SEC. 1177. WRONGFUL DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

''(a) OFFENSE.—A person who knowingly—

''(1) uses or causes to be used a unique health identifier in violation of a provision of this part;

''(2) obtains individually identifiable health information relating to an individual in violation of a provision of this part; or

''(3) discloses individually identifiable health information to another person in violation of a provision of this part,

shall be punished as provided in subsection (b).

''(b) PENALTIES.—A person described in subsection (a) shall—

''(1) be fined not more than $50,000, imprisoned not more than 1 year, or both;

''(2) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and

''(3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, fined not more than $250,000, imprisoned not more than 10 years, or both.

''SEC. 1178. EFFECT ON STATE LAW.

''(a) GENERAL EFFECT.—

''(1) GENERAL RULE.—Except as provided in paragraph (2), a provision or requirement under this part, or a standard or implementation specification

adopted or established under sections 1172 and 1173, shall supersede any contrary provision of State law, including a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form.

''(2) EXCEPTIONS.—A provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1172 and 1173, shall not supersede a contrary provision of State law, if the provision of State law—

''(A) imposes requirements, standards, or implementation specifications that are more stringent than the requirements, standards, or implementation specifications under this part with respect to the privacy of individually identifiable health information; or

''(B) is a provision the Secretary determines—

''(i) is necessary to prevent fraud and abuse, or for other purposes; or

''(ii) addresses controlled substances.

''(b) PUBLIC HEALTH REPORTING.—Nothing in this part shall be construed to invalidate or limit the authority, power, or procedures established under any law providing

for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

"SEC. 1179. HEALTH INFORMATION ADVISORY COMMITTEE.

"(a) ESTABLISHMENT.—There is established a committee to be known as the Health Information Advisory Committee (in this section referred to as the 'committee').

"(b) DUTIES.—The committee shall—

"(1) provide assistance to the Secretary in complying with the requirements imposed on the Secretary under this part;

"(2) study the issues related to the adoption of uniform data standards for patient medical record information and the electronic exchange of such information;

"(3) report to the Secretary not later than 4 years after the date of the enactment of this part recommendations and legislative proposals for such standards and electronic exchange; and

"(4) generally be responsible for advising the Secretary and the Congress on the status of the implementation of this part.

"(c) MEMBERSHIP.—

"(1) IN GENERAL.—The committee shall consist of 15 members of whom—

"(A) 3 shall be appointed by the President;

"(B) 6 shall be appointed by the Speaker of the House of Representatives after consultation with the minority leader of the House of Representatives; and

"(C) 6 shall be appointed by the President pro tempore of the Senate after consultation with the minority leader of the Senate.

The appointments of the members shall be made not later than 60 days after the date of the enactment of this part. The President shall designate 1 member as the Chair.

"(2) EXPERTISE.—The membership of the committee shall consist of individuals who are of recognized standing and distinction in the areas of information systems, information networking and integration, consumer health, health care financial management, or privacy, and who possess the demonstrated capacity to discharge the duties imposed on the committee.

"(3) TERMS.—Each member of the committee shall be appointed for a term of 5 years, except that the members first appointed shall serve staggered terms such that the terms of not more than 3 members expire at one time.

''(4) INITIAL MEETING.—Not later than 30 days after the date on which a majority of the members have been appointed, the committee shall hold its first meeting.

''(d) REPORTS.—Not later than 1 year after the date of the enactment of this part, and annually thereafter, the committee shall submit to the Congress, and make public, a report regarding—

''(1) the extent to which persons required to comply with this part are cooperating in implementing the standards adopted under this part;

''(2) the extent to which such entities are meeting the privacy and security standards adopted under this part and the types of penalties assessed for noncompliance with such standards;

''(3) whether the Federal and State Governments are receiving information of sufficient quality to meet their responsibilities under this part;

''(4) any problems that exist with respect to implementation of this part; and

''(5) the extent to which timetables under this part are being met.''.

(b) CONFORMING AMENDMENTS.—

(1) REQUIREMENT FOR MEDICARE PROVIDERS.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(A) by striking ''and'' at the end of subparagraph (P);

(B) by striking the period at the end of subparagraph (Q) and inserting ''; and''; and

(C) by inserting immediately after subparagraph (Q) the following new subparagraph:

''(R) to contract only with a clearinghouse (as defined in section 1171) that meets each standard and implementation specification adopted or established under sections 1172 and 1173 on or after the date on which the clearinghouse is required to comply with the standard or specification.''.

(2) CLERICAL AMENDMENTS.—

(A) Title XI (42 U.S.C. 1301 et seq.) is amended by striking the title heading and inserting the following:

''TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION''.

(B) Parts A and B of title XI (42 U.S.C. 1301 et seq.) are amended by striking ''this

title'' each place such term appears and inserting ''parts A and B of this title''.

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